Missouri

UNIFORM APPLICATION
FY2011

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

42 U.S.C.300x-21 through 300x-66

OMB - Approved 07/20/2010 - Expires 07/31/2013

(generated on 10/8/2010 11:47:45 AM)

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at http://bgas.samhsa.gov.

Form 1

DUNS Number: 780871430-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

1. State Agency to be the Grantee for the Block Grant:

Agency Name:	Missouri Department of Mental Health
Organizational Unit:	Division of Alcohol and Drug Abuse
Mailing Address:	1706 E. Elm Street, P.O. Box 687
City:	Jefferson City Zip Code: 65102-0687

2. Contact Person for the Grantee of the Block Grant:

Name:	Mark Stringer
Agency Name:	Missouri Department of Mental Health Div. of Alcohol and Drug Abuse
Mailing Address:	1706 E. Elm Street, P.O. Box 687
City:	Jefferson City Code: 65102-0687
Telephone:	(573) 751-9499 FAX: (573) 751-7814
Email Address:	mark.stringer@dmh.mo.gov

3. State Expenditure Period:

From: 7/1/2008 To: 6/30/2009

4. Date Submitted:

Date: Original: ◉ Revision: ○

5. Contact Person Responsible for Application Submission:

Name:	Mark Stringer	Telephone:	(573) 751-9499
Email Address:	mark.stringer@dmh.mo.gov	FAX:	(573) 751-7814

Form 2 (Table of Contents)

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)
IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929
X. Maintenance of Effort Regarding State Expenditures, Section 1930
With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI. Restrictions on Expenditure of Grant, Section 1931
XII. Application for Grant; Approval of State Plan, Section 1932
XIII. Opportunity for Public Comment on State Plans, Section 1941
The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV. Requirement of Reports and Audits by States, Section 1942
XV. Additional Requirements, Section 1943
XVI. Prohibitions Regarding Receipt of Funds, Section 1946
XVII. Nondiscrimination, Section 1947
XVIII. Services Provided By Nongovernmental Organizations, Section 1955
I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Missouri
Name of Chief Executive Officer or Designee:
Signature of CEO or Designee:
Title: **Date Signed:** **If signed by a designee, a copy of the designation must be attached**

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 C.F.R. Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 C.F.R. Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 C.F.R. Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 C.F.R. Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of

his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application. **5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE** Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.	By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly. The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
b. material change

For Material Change Only:

Year _____ Quarter _____
date of last report

4. Name and Address of Reporting Entity:

☐ Prime ☐ Subawardee

Tier _____ , if known: _____

Congressional District, *if known:* _____

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known:* _____

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:

$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT:
PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following statutory requirements:

- 42 U.S.C. §300x-29, 45 C.F. R. §96.133 and 45 C.F.R. §96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five pages,** describe:

- How your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need.
- Include a definition of your State's sub-State planning areas (SPA).
- Identify what data is collected, how it is collected and how it is used in making these decisions.
- If there is a State, regional or local advisory council, describe their composition and their role in the planning process.
- Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.
- Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

Describe how your State evaluates activities related to ongoing substance abuse prevention and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

- 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in

such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)
Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development
Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels —processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System
Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes
Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

Planning Process

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) uses five state planning regions: Northwest, Central, Eastern, Southwest, and Southeast. The ADA planning regions are further divided into 20 service areas consisting of clusters of counties. The largest metropolitan service areas comprise one or two counties while some of the rural service areas cover up to nine counties (http://www.oas.samhsa.gov/subState2k5/secD.htm#MO).

ADA planning utilizes prevalence data, substance abuse indicators, treatment admissions data, population estimates, needs assessments, and outcomes data. Prevalence data, which encompasses alcohol and drug use, abuse, and dependence, is derived from several national and state surveys. ADA acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavioral Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS), and state data collected from 13 university campuses and 6 private campuses using the Missouri College Health Behavior Survey (MCHBS). ADA annually updates prevalence estimates using the most current survey data.

ADA collects an array of substance abuse indicator data, mostly from other state agencies. The indicators include a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the ADA planning regions, service areas, and the state.

Substance abuse treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Aggregate data include basic demographic, substance abuse problem, and treatment services information, and are annually assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and the state.

The prevalence estimates, substance abuse indicators, and treatment admissions data are compiled for the annual Status Report on Missouri's Alcohol and Drug Abuse Problems, and posted on the ADA public website at:

http://dmh.mo.gov/ada/rpts/status.htm. The report provides a narrative epidemiologic profile of the impact of substance abuse on the state and the challenges substance abuse issues present to the state.

Substance abuse needs assessments consist of separate assessments for treatment and prevention. ADA uses state and sub-state data – particularly the age group estimates for alcohol or illicit drug dependence or abuse – from the NSDUH in its treatment needs assessment. Treatment needs assessment calculations are routinely updated for the Treatment Needs Summary Matrix (form 4) and Treatment Needs by demographic subgroup (form 5) for the Substance Abuse Prevention and Treatment Block Grant application and for decision items in the annual ADA budget request. Analysis typically involves comparing need with number served at the planning region and/or service area levels to gage unmet need. Data analysis has been used effectively to prioritize expansion of specific services into un-served or under-served areas. ADA also uses a geographic information system (GIS) to map and analyze data to identify service gaps.

Prevention needs assessments make extensive use of the survey data and substance abuse indicators. A variety of methods are used in the data analysis. These include comparisons of state and national rates and trends; numerical changes and/or population-based rate changes of various indicators at the county, service area, planning region, and statewide levels; and visual examination of GIS-generated cloropeth maps that illustrate geographic variances.

A needs assessment was conducted in 2005 for the Strategic Prevention Framework State Incentive Grant (SPF SIG). The State Epidemiology Workgroup (SEW) conducted data collection and analysis on behalf of the Governor's Advisory Committee (GAC), the steering committee for the SPF SIG. The assessment included comparisons of Missouri and national rates of alcohol and illicit drug use, state and national comparisons of indicators in the State Epidemiology Data Set (SEDS), and calculation of Missouri county population-adjusted rates for many of the indicators tracked by the ADA Status Report. To further enhance planning and decision-making, SEW staff mapped the county rates using GIS to provide a visual depiction of areas of the state that had the highest rates for various substance abuse indicators and presented quarterly reports to the GAC. The SEW consolidated its analysis in the *SPF SIG Initial Needs Assessment* report presented to the GAC in December 2005. Based on the relatively higher rates of alcohol use and alcohol related problems in Missouri compared to the U.S., the GAC adopted the goal of reducing risky drinking behavior – particularly underage and binge alcohol use among adolescents and young adults 12-25 years of age. Data to measure baseline rates of risky drinking by county were not available. Therefore, three proxy measures related to alcohol abuse were selected for analysis to determine areas of greatest need. County-level analyses of the three proxies – alcohol

related emergency room episodes, alcohol related vehicle crashes, and alcohol related juvenile court referrals – were combined to form a county ranking of severity within each of the ADA planning regions. That process ensured that proposed projects were funded on the basis of need. The SEW staff issued the SPF SIG Needs Assessment Update in April 2009. The report exclusively examined trends and progress in reducing alcohol use and alcohol related problems, including the most recent prevalence rates and data on the proxy measures.

Aside from the development of quantitative data, sub-state planning involves input on program needs from advisory councils, staff, service providers, and other informed individuals. The SAC is a statutory body comprised of up to 25 members appointed by the ADA director to three-year overlapping terms. Current SAC membership includes consumer advocacy groups, service providers, and representatives from other state and local agencies. Among other duties, the SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes programs to reduce the debilitating effects of alcohol and other drugs; and disseminates information on substance abuse prevention, treatment, and rehabilitation. Treatment and prevention subcommittees of the SAC have active roles in providing information, resources, and recommendations. During the past year, the SAC has studied several planning initiatives that impact prevention and treatment services. These include the Department of Mental Health's proposal in its 2009 Strategic Plan to create Centers of Excellence that link addiction treatment and prevention services with broader healthcare and social service systems; an ADA proposal to create Recovery Oriented Systems of Care that emphasize prevention and treatment support, recovery as a process, and involvement of families and communities; and the ADA Strategic Plan for Prevention for 2010-2015.

ADA has three district offices and two satellite offices staffed by district administrators and treatment coordinators, who provide referrals to ADA programs, monitor service providers, and provide technical assistance to service providers. The ADA executive management team includes the ADA director and deputy director, the district administrators, the prevention director, the clinical treatment director, the Access To Recovery project director, the director of operations, the Substance Abuse Traffic Offenders Program (SATOP) director, head of workforce development, and the ADA research coordinator. The ADA executive staff utilizes data from needs assessments, analyses prepared by the ADA research staff and fiscal staff, and recommendations from the SAC to formulate the ADA annual budget, reallocations, and budget cuts when required. The use of these multiple sources of information helps to ensure that ADA expends its SAPT Block Grant funds in communities and for populations with the greatest need.

ADA facilitates performance monitoring using the prevention and treatment National Outcomes Measures (NOMs); the prevention Minimum Data Set (MDS); and the

Treatment Episode Data Set (TEDS). ADA provides funding to administer the MSS to secondary school students. ADA also provides funding for the Partners in Prevention program, which conducts the MCHBS for college students. These data sources provide important information to monitor sub-state prevalence rates for Missouri adolescents and young adults. Through SPF SIG funding, the University of Missouri is currently examining alcohol data from the BRFS to determine if sufficient data from that survey are available to measure program effects of the 18 community coalition projects funded by the SPF SIG.

Missouri's SEW was established under the SPF SIG grant. Membership included representatives from the U.S. Drug Enforcement Agency; the St. Louis Mental Health Board; the Missouri Institute of Mental Health; and Missouri state agencies including the Department of Mental Health, the Department of Health and Senior Services, the Department of Public Safety, and the Department of Corrections. The Division of ADA is in the process of getting technical assistance from the Center for Application of Prevention Technologies (CAPT) on the assessment and revitalization of the State's SEW. In addition, the State is responding to the request for proposals, issued by the SAMHSA contractor Synetics, to enhance work established by the SEW under the SPF SIG and expand the SEW's focus to mental illness.

FY 2011 - FY 2013 Prevention Plan

In FY 2010, ADA developed, in collaboration with the SAC prevention subcommittee and prevention stakeholders, its five year strategic plan for prevention. The State's FY 2011 – FY 2013 Prevention Plan for the Block Grant application is based on the five year strategic plan.

Problem Assessment

Selection of the ADA prevention priorities is data-driven. Missouri continues to have higher binge drinking rates than the U.S. among adolescents 12-17 years old and among young adults 18-25. The NSDUH also indicates that Missouri residents perceive less risk in binge alcohol use than their national counterparts. Among adolescents and adults ages 12 and older, Missouri residents also have lower than U.S. rates for perceiving risk in using marijuana monthly. In Missouri, the average ages of first use of alcohol and marijuana are 13.2 and 13.5 years, respectively. A large body of research indicates that delaying the age of first use of these substances reduces the risk of substance abuse problems later in life. Among the 40,049 individuals admitted to ADA treatment programs in FY 2009, over two-thirds identified alcohol (41%) or marijuana (27%) as their primary drug problem. Changing the culture of acceptability of substance use also requires reducing youth tobacco use. Missouri residents in all age groups have consistently had higher smoking rates than the national rates. Missouri annually has more than 14,000 smoking affected births and almost 10,000 smoking induced deaths. Every year, Missouri leads the nation in the number of methamphetamine labs confiscated. Methamphetamine annually accounts for approximately 10% of the ADA treatment admissions. More than 1,500 children are removed from their homes and separated from their parents each year due to parental substance abuse.

Prevention System Assessment

The SPF SIG model has strengthened Missouri's prevention infrastructure. The ADA prevention staff and staff of the Statewide Training and Resource Center and the 11 Regional Support Centers (RSC) have learned the model and incorporated it into their prevention work. The RSCs develop, implement, and evaluate comprehensive strategic plans with identified target outcomes based on community needs. They utilize data to identify needs, gaps, and resources; implement evidence-based programs and environmental strategies that address the needs; and evaluate services and progress toward achieving desired outcomes. RSCs have formal agreements with community-level partners to collaborate in community planning and in selecting and implementing programs and practices that are culturally appropriate. They also collect and report NOMS and other data and information to ADA.

Prevention System Capacity Development

In the planning stage of the SPF SIG, the GAC and SEW had active roles in identifying and reviewing pertinent data and making strategic recommendations. As the project transitioned from planning to implementation, participation by these groups waned. An expanded or reformulated SEW might be able to provide additional information, data, and support. ADA has begun consulting with the Southwest CAPT on this issue, and will continue efforts to make the SEW a viable resource. Although the prevention methodology that ADA uses has improved, prevention faces future capacity challenges. ADA lost its Safe and Drug Free Schools funding, which in past years was used to administer mini-grants to community coalitions for targeted prevention projects. ADA is also in the final year of SPF SIG funding, and it is unknown how many of the 18 community-level coalitions funded through the grant will be able to sustain their operations.

Implementation of a Data-Driven Prevention System

The five-year ADA Strategic Prevention Plan retains two dominant elements of the SPF SIG project: the use of data-driven methodologies and an emphasis on reducing alcohol abuse. The Strategic Plan calls for a reduction in binge drinking by Missouri's youth and young adults; delayed onset of first use of alcohol and marijuana; reduction in past 30-day use of alcohol and marijuana among youth; increase in awareness among youth of the potential harm of alcohol, tobacco, marijuana, and other drugs; reduction in prescription drug misuse among youth and older adults; reduction in smoking and tobacco use among youth; reduction in number of clandestine methamphetamine labs; reduction in alcohol, tobacco, and illicit drug use among pregnant women; and continued compliance with requirements of the Synar Amendment to reduce the sale of tobacco products to minors. During the next three fiscal years, ADA will allocate its prevention funding to recipients who can demonstrate an ability to identify, describe, and quantify problems and needs consistent with ADA goals, objectives, and desired outcomes; identify intervening variables that contribute to the problems; develop plans that use the CSAP core strategies to address the problems; implement the plans effectively and with fidelity; collect data to monitor outcomes; evaluate the impact of the projects; and make recommendations to improve future program efforts.

Evaluation of Primary Prevention Outcomes

The Strategic Prevention Plan has established the goal of reducing substance use by the target populations by FY 2015 compared to rates that prevailed in FY 2007, the data baseline year. During the FY 2011 - FY 2013 three-year prevention component of the state plan, ADA will annually document these rates and compare them to the baselines to determine if the prevention programs are making progress in reducing rates. ADA will continue to monitor the substance abuse indicators as part of the prevention plan review and revision. ADA will conduct sub-state analysis of the data to identify regions

of the state with the highest rates, and to determine if the prevention programs are adequately addressing the substance abuse problems in their geographic areas. The Regional Support Centers will use the evaluation data to develop their regional prevention plans and prioritize technical assistance to the prevention programs.

The SPF SIG ends in FY 2010, and the staff will be completing all evaluation activities and submitting their reports as part of the grant close-out. Based on the findings, ADA will identify any systemic changes that should be made to Missouri's prevention network.

FY 2011 – FY 2013 Treatment Plan

In FY 2010, the ADA executive management team drafted and submitted the state priorities to the SAC for their review and feedback. The state priorities became the foundation for the State's three-year treatment plan.

Defend ADA Budget from Further Cuts

Due in part to economic recession and declining state revenues, state funding for substance abuse programming has sustained several cuts. The budget for FY 2012 is also expected to be bleak. The Division of ADA recognizes the need to convey the importance of funding substance abuse programming to policy makers, elected officials, and other stakeholders. The successful marketing of cost-benefit results, outcome data, and success stories will play a key role in preserving support for the State's current infrastructure. Further growth in Missouri's correctional population will increase the need for additional prisons. The Division of ADA serves over 28,000 offenders on parole or probation each year. The services provided by ADA help the recovering offender maintain a substance-free, crime-free lifestyle in the community.

The Division of ADA will explore effective ways to communicate and market the success of its programming. The Division will continue to produce bulletins highlighting treatment programs and division initiatives that relay the cost of substance abuse and the benefits of treatment. These one-page bulletins are posted to the ADA public website: http://dmh.mo.gov/ada/Bulletins.htm.

The Division of ADA will continue to study the impact of substance abuse and substance abuse treatment through data linkages and analyses. During FY 2011, ADA research staff will examine medical costs using the Medicaid claims data to determine how substance abuse treatment impacts medical costs for individuals with a substance abuse diagnosis. The results of this study will be summarized in a report. The Division will continue to develop and enhance effectiveness measures for its budget items.

Provide For and Encourage the Use of Medication-Assisted Treatment and Other Evidence-Based Practices

Efforts to institutionalize medication-assisted treatment (MAT) took form with the Robert Wood Johnson Advancing Recovery grant in 2005. Contracts were amended in 2007 to add medication services. In 2009, the Division was successful in securing general revenue funding for medications to treat addiction. In recent years, the Division has worked with providers to ensure effective implementation of MAT. The Division of ADA is using billing data to monitor utilization of MAT services or lack thereof and to target the delivery of technical assistance and other interventions. The Division is looking for use of evidence-based practices (EBP) in its monitoring efforts with providers. In FY

2011, ADA research staff will work toward developing performance measures related to MAT and other EBP.

In FY 2010, an early intervention program was added which provides for the use of Motivational Interviewing (MI) for those individuals who do not meet the criteria for ADA admission but do need some level of intervention. In FY 2011, the Division will monitor utilization of these services. The Division will continue to look for ways to engage individuals who need early intervention or treatment services.

Prepare State for Healthcare Reform and Integration of Behavioral Healthcare with the Broader Healthcare System

At the state level, a Cabinet Healthcare Reform team was established to assess the changes and opportunities that will come with Healthcare Reform (HCR). The Department of DMH is the lead agency for the provision on Centers for Excellence in Depression. For other provisions, DMH is a collaborating agency as a number of HCR provisions will impact the department and its consumers. In summer 2010, DMH convened nine workgroups to address issues related to Healthcare Reform (HCR). These groups include: 1) Medicaid Expansion to 133% FPL, 2) CHIP FMAP Increase, 3) Medicaid Plan Options (1915I & 1915K), 4) Healthcare Homes for Chronically Ill, 5) Money Follows the Person, 6) Centers of Excellence for Depression, 7) Medicaid IMD Demo Project, 8) ABA Credential, and 9) State Healthcare Workforce Development. Throughout the summer, the workgroups met to assess the impact of HCR provisions, develop estimates of numbers impacted by HCR who will need behavioral health services, and establish action plans. The workgroups presented their initial findings to the Mental Health Commission in August 2010. The state-level and department-level workgroups continue to work on HCR as additional federal guidance becomes available. Additional research will be conducted on benchmarks and benchmark packages; the fiscal impact of serving current DMH consumers, as well as new consumers under the expansion provision; and on the service array to determine qualified services and to identify additional services that will be required to meet certain HCR provisions.

Improve the Process for Individualized Care

The Division of ADA has always maintained the expectation that consumers receive substance abuse treatment services in the manner, frequency, and intensity that is commensurate with the assessed needs of the individual and so prescribed in the treatment plan. The economic downturn has forced cuts to the substance abuse treatment system budget, while the need for treatment among Missourians stays constant or likely increases. Concurrently, the nation is poised to implement sweeping reforms in healthcare that could both vastly increase the demands on the substance abuse treatment system, as well as mechanistically and philosophically change the way

care is delivered. These issues have required that the expectation for individualized services become the driving focus behind new initiatives, along with the maximization of existing services.

To that end, the Division has increased the frequency and scope of provider communications as it relates to Division policy, federal reform updates, and program development. The Division regularly holds meetings with the Executive Directors of substance abuse treatment providers, as well as with the Coalition of Community Mental Health Centers, in which many addiction service providers participate. There are monthly ADA Change Leader calls held to discuss the implementation of evidence-based practices and plans are being made to reformat these calls to align with NIATx principles for process improvement. Finally, the Division has established a distribution list that includes direct clinical supervisory staff for contracted organizations. This venue if often used to relay policy-related memoranda, disseminate information on local and federal resources, and obtain feedback from providers regarding initiatives, obstacles, progress, etc on initiatives and programming. Most notably, the Division has been working to ensure providers clearly understand that MAT is a service that may not be suitable for all, but which must be available to all for whom it is deemed clinically appropriate.

Division staff that are charged with monitoring treatment providers (billing, certification, safety and basic assurances) are well-informed regarding evidence-based and best practices in substance abuse treatment. They are able to deliver technical assistance directly and/or identify areas for which additional provider training may be needed, to include better methods for individualizing services.

Finally, the Division is exploring options for expanding the early intervention services available to providers (as described above). Specifically, a program is being developed for referrals from the Department of Corrections that would better address lower-intensity service needs. This may offset unnecessary referrals of these individuals to higher intensity, more costly services in the formal treatment system.

Enhance and Expand the Qualified Workforce

A key challenge for many states, including Missouri, is enhancing and expanding the qualified workforce through recruitment, retention, training, and development. During FY 2011, ADA will convene a workgroup with representation from the Missouri Substance Abuse Professional Credentialing Board, the Mid-America Addiction Transfer Center and the Missouri Association of Community Task Forces. This workgroup will focus on developing a sound infrastructure to support a skilled workforce.

Several provisions of the Affordable Care Act offer new grants to States to fund projects designed to grow and increase the knowledge of the health care workforce. The

Division of ADA has partnered with the Missouri Workforce Investment Board of Economic Development, the Department of Health and Senior Services, the Missouri Area Health Education Center, and the Department of Insurance to apply for a planning grant under Section 5102 of the Affordable Care Act. Section 5102 authorizes funds for States to plan and implement workforce development activities in hopes of increasing the primary care health workforce by 20 – 25% over the next ten years.

The Division will continue to forge partnerships with stakeholders to further enhance and expand the qualified workforce through career ladders and collaborative relationships with secondary and post-secondary institutions of education. Strategies for involving treatment agencies in recommended practices for recruitment, retention, development, and training will be initiated.

Improve the State's Substance Abuse Traffic Offender (SATOP) Program

In FY 2010, the Division requested and received approval to increase the SATOP offender fees to support an expansion of the more intensive levels of care. Within the SATOP program, the Serious and Repeat Offender (SROP) program currently provides more long-term treatment services for chronic DWI offenders in the Greene County Treatment Court program. The SROP program will be expanded statewide to support other treatment court programs in the state. The expansion process will add three new SROP providers in FY 2011 with more to follow in subsequent years. In addition, the offender fee increases will be used to fund medication-assisted treatment in the SROP programs.

The Division of ADA has identified several initiatives to improve and assure the delivery of appropriate and effective services for DWI offenders. Over the next three years, ADA will encourage SATOP providers to acquire national accreditation. This is consistent with the direction the Division is going with all of its treatment providers. The Division will also encourage legislative changes that prevent or at least further restrict judicial modifications to professional substance abuse assessment recommendations of DWI offenders. The Division of ADA will work to better define the separation of private probation and SATOP services to prevent conflicts of interest and protect consumer quality of care. The Division will initiate a comprehensive, scientific program evaluation of its SATOP program to identify effective and ineffective components of the SATOP program.

Maintain an Appropriate Continuum of Substance Abuse Treatment and Support Services to Achieve the Five Domains of Recovery

The individualization of treatment services is crucial to each consumer's success and the sustainability of the broader system. This ensures that consumers get what they need, no more no less. However, a key component of treatment individualization is the

assurance that a wide array of supports and interventions are available to consumers presenting with diverse needs. There should be abundant options to help consumers pursue their unique paths to recovery, with the expectation that all will obtain success in five key domains of recovery: abstinence, stable housing, improved employment/education status, decreased criminal activity/legal concerns, and increased social connectedness. Missouri currently offers detoxification to all consumers; however, one goal is to add this service to the Medicaid state plan to assure that federal funds can be leveraged when providing modified medical detoxification to those that are Medicaid eligible. Outpatient programs can range from daily attendance, to participation on an as needed basis. Services available in outpatient treatment include the following: assessment, individual and group counseling, group education, family therapy, nursing services, physician services, medications, individual co-occurring disorders services, trauma-focused services, and community support/case management. For individuals that require time-limited structure and supervision to support them in the earliest stage of recovery, residential support services are available. For opioid-addicted individuals in need of maintenance therapies, there are methadone programs. These programs are being encouraged and educated about other medications that can assist those addicted to opiates, providing a more comprehensive set of medical interventions for maintenance therapies or medically-supervised withdrawal. Women with children in their care can obtain daycare services to assist them in engaging in services. Transitional housing supports are available for those that are in less intensive stages of formal treatment and/or who are in intermediate phases of recovery. The Division is encouraging treatment providers to expand their service array to include more transitional and supportive housing options. This will be a continued and expanded focus of attention in the next three years.

In FY 2010, the Division of ADA turned attention toward individuals in need of “early intervention” – education and motivational enhancement services – to benefit those who may be in the early stages of substance abuse and for whom intensive formal treatment programs are not appropriate. The Division hopes to expand the availability of this service and is currently working to develop an offender-specific program of early intervention. In the future, the Division also wants to offer education services to family members. This particular service is not funded unless it is delivered in the context of family therapy and/or individual codependent counseling. Families affected by substance abuse could benefit from these services whether or not the primary abuser accesses treatment.

Recovery supports have long been available to consumers participating in Access To Recovery (ATR) grant services. These non-clinical interventions help support consumers in formal treatment and/or provide services to consumers in the early stages of recovery that are struggling to get their needs met and continue in their substance-

free efforts. The Division will make efforts to make recovery support services available to all consumers.

Convert Remaining Traditional Addiction Treatment Programs to the CSTAR Model

Historically, about 25% of the consumers served in the Division's Primary Recovery Plus (PR+) programs were Medicaid eligible. The PR+ program is not a Medicaid reimbursable program, but the Division's CSTAR program is Medicaid reimbursable. In FY 2009, the Division began an initiative to convert PR+ programs to CSTAR in order to maximize resources available for substance abuse treatment programming. By the end of FY 2010, twenty PR+ programs had converted to CSTAR and twelve PR+ programs remain. The Division will continue to work with remaining PR+ programs to move toward a CSTAR model. In addition to maximizing current resources, this initiative will better position ADA providers for HCR, given that an estimated 22,000 ADA consumers will be in the Medicaid 133% FPL expansion population.

Improve Efforts to Track Capacity Management and Referral Processes

The Division of ADA is seeking improvements in its tracking of capacity and demand for services. In spring 2010, ADA requested and received approval from CSAT for technical assistance on capacity management and wait list. In August 2010, ADA received an on-site visit from a CSAT-funded consultant to assist ADA in assessing its current processes and procedures in relation to capacity management and waiting list issues. The on-site visit consisted of one day with ADA and IT staff followed by a provider conference call on the next day. The conference call provided the Division the opportunity to communicate to providers the necessity of tracking capacity and demand. ADA providers, with their experience of front-line issues and knowledge of agency operations, gave valuable input to the initial stages of the process. The Division of ADA has established an internal workgroup that together with further off-site technical assistance and provider input will develop recommendations for improved tracking of capacity and demand. The Division anticipates the need for changes to the department's information system. The workgroup will develop high-level specifications of those changes for review and approval by the department's IT steering committee. The ADA workgroup will also be responsible for developing an implementation plan.

Increase Utilization of System Data

The Missouri Department of Mental Health (DMH) implemented the web-based Customer Information Management Reporting and Outcomes system in fall 2006. Since then, the CIMOR system continues to evolve. A major re-design of the ADA TEDS screens and data tables was implemented in May 2010. Currently, ADA is in the process of creating an on-demand provider-level NOMS report in CIMOR for providers

to view. In addition, operational reports have been added to CIMOR to help providers manage certain populations (Block Grant priority populations, involuntary commitments, etc.) Over the next three years, ADA will increase its reporting focus on outcomes and process measures. Over the past year, ADA program staff have met regularly to identify and discuss process measures based on billing activity. Benchmarks still need to be established for the measures. Initial reports have been developed for some measures. These reports will be converted into MS reporting services for deployment to CIMOR. There have been some limitations with CIMOR's reporting functionality. DMH IT is currently developing a Data Central Reporting interface which will further facilitate report access. The Division anticipates more reliance on internal data analysis and reporting in support of monitoring activities.

In addition to provider-level reporting, ADA seeks to utilize more data linkages and cross-system data analysis. The Department of DMH gets bi-monthly installments of Missouri's Medicaid claims data and pharmacy transactions. During FY 2011, ADA research staff will examine medical costs using the Medicaid claims data to determine how substance abuse treatment impacts medical costs for individuals with a substance abuse diagnosis. The results of this study will be summarized in a report. The Division of ADA has developed linkage with the Missouri Department of Revenue to obtain quarterly installments of the Missouri driver's license file which includes DWI activity. The Division of ADA is using this data to monitor outcomes for the SATOP program. On an annual basis, ADA is acquiring prison admission data from the Missouri Department of Corrections. The Division is using this data to examine prison recidivism of ADA consumers. Over the next couple of years, ADA will seek to obtain hospital and emergency room admission data to further examine the impact of substance abuse and substance abuse treatment on healthcare costs.

Implement an Internal Quality Improvement Plan

In FY 2010, ADA received technical assistance from CSAT on the topic of performance improvement. The purpose of the technical assistance was to help ADA develop its first continuous quality improvement (CQI) plan and process. The Division of ADA received a site visit by the CSAT consultant in November 2009. Since the visit, the Division has determined that its Policy and Development (PAD) group, which consists of ADA managers and supervisors, will assume the role of the quality improvement team. The PAD group meets every two weeks, with CQI being a focus of one of those monthly meetings.

A basic CQI plan has been developed but is still a work in progress. As part of that plan, each ADA unit is responsible for identifying potential performance measures for their unit and processes. Each unit will present and discuss these measures at a PAD meeting with the PAD group providing feedback and guidance with the final selection

and subsequent monitoring of those measures. Over the course of FY 2011, it is anticipated that an initial set of performance measures will be adopted for CQI monitoring. It will be the responsibility of the PAD to assess performance and decide on a course of action.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed and how to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The SAC has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. Most SAC members have leadership roles as managers, advocates or volunteers in the substance abuse service delivery system. Current representation includes treatment, recovery support, and prevention service providers; the Missouri National Guard; the Department of Corrections; the Missouri Police Chiefs Association; drug court; the Department of Health and Senior Services; and the Department of Elementary and Secondary Education. The SAC meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning, performance measurement development, and other aspects of service delivery system. The SAC chairperson appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. SAC members continually seek input from individuals, agencies, and organizations impacted by substance abuse.

The content of the SAPT block grant application's state plan reflects recommendations originating from the SAC and other sources, including direct citizen input. The compressed time frame for preparing the SAPT Block Grant application generally precludes a review by the SAC and other interested persons prior to its submission to the Center for Substance Abuse Treatment (CSAT) in October of each year. To facilitate ongoing review, each application is posted to the ADA public website at http://www.dmh.missouri.gov/ada/blockgrant.htm. The array of links to current and past block grant applications is preceded by a narrative that explains the purpose of the block grant and solicits comments from any interested persons (http://www.dmh.missouri.gov/ada/reportsstatistics.htm#blockgrant.). The solicitation for comments is worded as:

The CSAT requires each state to have a process to facilitate public comment in developing the plan and the application for Block Grant funds. The Division encourages interested persons to review the application and submit comments and suggestions that can be considered for inclusion in the next Block Grant application submission. Please mail your comments to: Director, Division of Alcohol and Drug

Abuse; P.O. Box 687; Jefferson City, MO 65102. *You can also e-mail your comments to:* adamail@dmh.mo.gov.

ADA notifies the SAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's central and district office staff for consideration in developing the next application. This process provides ongoing access to the SAPT applications and feedback from the advisory network and general public.

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:

2008 population estimates of service areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specify method)

maintenance of existing services

2 Size of gaps between resources (as measured by)

number of consumers served in FY 2008

and needs (as estimated by)

prevalence estimates (Missouri 2007-2008 NSDUH)

Other (specify method)

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: meth lab seizures	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northwest Region	1,435,672	110,342	10,549	2,395	1,051	42,501	3,824	7,592	10,827	45	10	13	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: meth lab seizures	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Central Region	782,002	63,447	4,804	1,326	453	24,438	2,063	5,534	3,967	184	7	3	1

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: meth lab seizures	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Eastern Region	2,098,164	172,869	20,504	3,542	1,101	66,585	7,163	11,938	13,362	522	8	12	2

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: meth lab seizures	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southwest Region	903,971	60,688	4,736	1,519	38	23,376	1,748	5,868	4,447	313	6	5	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southeast Region	691,796	49,654	2,424	1,173	241	19,125	1,125	4,611	4,305	423	8	3	1

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2008 6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Needing treatment services	B. That would seek	A. Number of DWI	B. Number of drug-	C. Other: meth lab seizures	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

			treatment		treatment		treatment	arrests	related arrests				
State Total	5,911,605	457,000	43,017	9,955	2,884	176,025	15,923	35,543	36,908	1,487	8	9	1

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	40,540	17,506	15,294	2,894	2,566	15	14	45	39	87	76	656	577	410	361	21,197	18,562	416	365
18 - 24 Years Old	140,378	72,309	41,295	11,954	6,927	64	37	185	106	358	206	2,709	1,558	1,695	975	87,554	50,119	1,720	985
25 - 44 Years Old	186,589	90,576	60,413	14,974	10,134	80	53	232	156	448	301	3,393	2,280	2,123	1,426	109,672	73,323	2,154	1,440
45 - 64 Years Old	79,150	39,580	24,471	6,543	4,105	35	22	101	63	196	122	1,483	923	928	578	47,925	29,701	941	583
65 and Over	10,343	7,611	765	1,258	128	7	1	19	2	38	4	285	29	178	18	9,215	929	181	18
Total	457,000	227,582	142,238	37,623	23,860	201	127	582	366	1,127	709	8,526	5,367	5,334	3,358	275,563	172,634	5,412	3,391

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Under 42 U.S.C. §300x-29 and 45 C.F.R. §96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

Determination of Estimates for Form 4 and Form 5

Form 4:

Column 1: Substate planning area
The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as service areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population
The population of each sub-state region listed on Form 4 is based on the 2008 population estimates prepared by the U.S. Census Bureau and the Missouri Census Data Center.

Column 3: Total population in need
The estimate for total population in need (457,000) was obtained from the National Survey on Drug Use and Health (NSDUH) 2007-2008. The number with alcohol or illicit drug dependence or abuse is used as a proxy for treatment need. Sub-state estimates were obtained by allocating the total in need (457,000) by the portion derived from the NSDUH 2002-2008 sub-state estimates that were obtained from the Office of Applied Studies as a result of a special data request from the State.

Missouri State Treatment Needs Assessment Program (STNAP-II) study, funded by CSAT and completed in 2003, estimated that 16% of household consumers would seek treatment and 50% of non-household residents would seek treatment. Therefore a rate of 20% was used to determine the number of consumers who would seek treatment. In FY 2008, ADA provided substance abuse treatment services to 48,383 Missouri residents whose county of residence (and therefore ADA planning region) is known. Subtracting the residents who accessed treatment services from the 91,400 who would seek treatment, an estimated 43,017 residents who would seek substance abuse treatment did not receive services. This unmet demand is reported by planning region in column 3B.

Column 4: Number of IVDUs in need
An NSDUH report found that overall injection drug use rates did not vary by county type or region (NSDUH Report - July 19, 2007). That same report found that the prevalence rate of injection drug use was 0.2% for the population age 12 and over. This rate was applied to the population age 12 and over of each ADA planning region. The STNAP-II study estimated that 50% of high-risk non-household adults would seek treatment. During the last four years, ADA has actually provided services to more than 50% of the estimated IVDU in some of the planning regions, so a potential treatment seeking rate of 75% of prevalence was applied to the IVDU to yield an estimated 7,466 IVDU that

would seek treatment. Subtracting the 4,583 IVDU whose county of residence (and therefore ADA planning region) is known and who received treatment services in FY 2008 from the 7,466 who would seek services, an estimated 2,884 IVDU who would seek treatment did not receive services. This unmet demand is reported by planning region in column 4B.

Column 5: Number of women in need

In spring 2010, the State obtained estimates of females dependent on or abusing alcohol or illicit drugs in the past year by planning region based on 2002-2008 NSDUH data. This was the result of a special request made to SAMHSA's Office of Applied Studies. About 39% of those in need are female and about 61% are male. These percentages were then applied to the estimate of total need (457,000) obtained from NSDUH 2007-2008 to obtain updated numbers of need by gender. The number of women in need of treatment was determined to be 176,025.

In determining the number of women seeking treatment, ADA applied the STNAP-II rate of women seeking treatment – roughly 17.5%. In FY 2008, ADA provided substance abuse treatment services to 14,882 Missouri women whose county of residence (and therefore ADA planning region) are known. By subtracting the women who accessed treatment services from the 30,804 who would seek treatment, an estimated 15,923 women have an unmet demand for treatment. This unmet demand is reported by planning region in column 5B.

Limitations of Data in Columns 3, 4, and 5

The NSDUH survey excludes individuals with no household address (e.g. homeless and/or transient persons not in shelters), active duty military personnel, residents of jails and hospitals, and individuals younger than age 12. NSDUH data relies on people self-reporting their behavior with respect to substance use. Data may be biased by interviewees either under-reporting or over-reporting their drug use. The NSDUH survey does check for internal consistency by using multiple questions measuring similar concepts.

Column 6: Prevalence of substance-related criminal activity

Driving while intoxicated (DWI) arrests are reported by local and state law enforcement agencies using the Missouri Department of Public Safety's (DPS) Driving While Intoxicated Tracking System (DWITS). Drug arrests are included in the Uniform Crime Reporting (UCR) system. Data is coded according to the county of arrest and aggregated to the ADA planning regions. Methamphetamine laboratory incidents are reported to the DPS from local and state authorities to the DPS and the DPS reports the data to the El Paso Intelligence Center National Seizure System (EPIC-NSS). Missouri has led the nation in the number of methamphetamine laboratory incidents.

Column 7: Incidence of communicable diseases

The 2008 data on acute and chronic hepatitis B, HIV&AIDS, and tuberculosis disease were provided by the Missouri Department of Health and Senior Services. The data are aggregated to the ADA planning regions using the county of residence at time of

diagnosis. The rates are based on the number of cases per 100,000 residents in accordance with 2008 population estimates.

Limitations of Data in Columns 6 and 7

Missouri does not have mandatory reporting of DWI arrests to DWITS but the reporting of DWI arrests to DWITS is more complete than that of the UCR. Reporting of drug arrests to UCR is voluntary. Reporting of methamphetamine laboratory incidents are voluntary with the exception of those law enforcement entities that receive grants from the MoSMART fund for the express purpose of methamphetamine enforcement.

Form 5:

The number of Missourians in need of treatment (457,000) from the 2007-2008 NSDUH was allocated over the age and gender groups and the white and black racial groups based on aggregate data from the 2002-2008 NSDUH that was generated by SAMHSA's Office of Applied Studies at the special request of the State. The distribution among the other racial groups was estimated based on the State's FY 2008 treatment admissions. The groups for non-Hispanic and Hispanic were generated by treatment rates as well.

Limitations of Data in Form 5

The data reported for Form 5 relies on the NSDUH data. The NSDUH survey excludes individuals with no household address (e.g. homeless and/or transient persons not in shelters), active duty military personnel, residents of jails and hospitals, and individuals younger than age 12. NSDUH data relies on people self-reporting their behavior with respect to substance use. Data may be biased by interviewees either under-reporting or over-reporting their drug use. The NSDUH survey does check for internal consistency by using multiple questions measuring similar concepts.

Even combining seven years' worth of NSDUH data, no statistics could be generated for the non-black minority groups. The State does not have funding to conduct its own household survey. Even when the State had a federal grant to conduct a household survey (STNAP-II) back in 2003, no statistics could be determined for these sub-populations. The State's treatment data is the best available proxy for the distribution of need when NSDUH is unable to provide sufficient estimates.

How Data from Form 4 and Form 5 are Used

Needs assessment data are used to determine and assess treatment gaps when new funding is available for program expansion or when budget cuts become necessary. In formulating its proposal for the federal Access to Recovery (ATR) III grant, the State analyzed treatment need data in addition to service infrastructure, provider performance, and the geographic distribution of the target populations that include offenders under the supervision of the Department of Corrections and military returning from Iraq and Afghanistan. This information will be used to determine the placement of recovery-oriented systems of care if an ATR III grant award is made to the state.

Treatment needs data along with program performance data are used in the budget decision items to justify program funding. Each year ADA must make the case that funding substance abuse programming is necessary. Missouri, like many states, has been in difficult budgetary conditions in recent years due to a national economic recession and increased unemployment. Cuts in state funding have been made to the substance abuse treatment system. When cuts are made, the State carefully considers the impact on sub-populations and geographic areas of the state. The groups most impacted by cuts to treatment funding are those that are not pregnant women nor intravenous injection drug users (IVDU's) nor Medicaid enrollees. It is a priority of ADA to defend the substance abuse prevention and treatment budgets from further cuts.

The State's treatment needs data will be enhanced and strengthened by making improvements to the state's ability to track capacity management, which is one of the State's priorities identified on Form 7. It is uncertain, however, if such improvements will provide additional information with regard to the IVDU's and pregnant women populations since the State already has contractual requirements that provide for the immediate admission of IVDU's and pregnant women.

The State will continue to collect and analyze substance abuse treatment and indicator data through the efforts of the ADA research unit and the State Epidemiology Workgroup (SEW). These efforts include

- the compilation of state and sub-state substance abuse data to be published in the ADA annual status report: http://dmh.mo.gov/ada/rpts/status.htm and
- the collection, analysis, and reporting of Missouri student survey data: http://dmh.mo.gov/ada/rpts/survey.htm.

The revitalization of the SEW and its integration into the planning and decision-making processes is a priority for the state. It is anticipated that work products will be produced from the SEW to support the state's planning process. This is also consistent with the State's priority to increase utilization of system data for informed decision-making and to enhance monitoring efforts.

Form 6 (formerly Form 11)

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

	(24 Month Projections)					
Activity	**A.SAPT Block Grant FY 2011 Award**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 19,677,104	$ 56,250,474	$ 11,232,044	$ 72,435,756	$	$
Primary Prevention	$ 5,249,723		$ 9,014,662	$ 1,821,706	$	$
Tuberculosis Services	$ 9,356	$ 41,560	$ 2,508	$ 18,950	$	$
HIV Early Intervention Services	$	$	$	$	$	$
Administration: (Excluding Program/Provider Lvl)	$ 1,312,431		$ 3,899,544	$ 3,184,178	$	$
Column Total	**$26,248,614**	**$56,292,034**	**$24,148,758**	**$77,460,590**	**$0**	**$0**

***Prevention other than Primary Prevention**

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 652,800	$ 337,098	$ 251,758	$ 0	$ 0
Education	$ 2,559,130	$ 1,284,856	$ 94,544	$ 0	$ 0
Alternatives	$ 219,212	$ 0	$ 7,448	$ 0	$ 0
Problem Identification & Referral	$ 25,675	$ 0	$ 1,904	$ 0	$ 0
Community Based Process	$ 748,894	$ 400,000	$ 608,650	$ 0	$ 0
Environmental	$ 344,392	$ 163,356	$ 73,728	$ 0	$ 0
Other	$ 318,831	$ 6,829,352	$ 175,670	$ 0	$ 0
Section 1926 - Tobacco	$ 380,788	$ 0	$ 608,004	$ 0	$ 0
Column Total	**$5,249,722**	**$9,014,662**	**$1,821,706**	**$0**	**$0**

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 1,101,308	$ 1,714,182	$ 387,378	$ 0	$ 0
Universal Indirect	$ 2,250,985	$ 2,030,888	$ 1,200,876	$ 0	$ 0
Selective	$ 1,897,429	$ 5,269,592	$ 233,452	$ 0	$ 0
Indicated	$ 0	$ 0	$ 0	$ 0	$ 0
Column Total	**$5,249,722**	**$9,014,662**	**$1,821,706**	**$0**	**$0**

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 funds?

◉ Yes ○ No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 321,360	$ 0	$ 321,360
Quality Assurance	$ 0	$ 0	$ 0	$ 0
Training (post-employment)	$ 0	$ 0	$ 0	$ 0
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 14,202	$ 524,952	$ 0	$ 539,154
Research and Evaluation	$ 0	$ 132,495	$ 0	$ 132,495
Information Systems	$ 0	$ 0	$ 0	$ 0
Column Total	**$14,202**	**$978,807**	**$0**	**$993,009**

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2011 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐ Competitive grants	Percent of Expense: %
☑ Competitive contracts	Percent of Expense: 98 %
☐ Non-competitive grants	Percent of Expense: %
☑ Non-competitive contracts	Percent of Expense: 2 %
☐ Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐ Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐ According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. I n addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐ Line item program budget

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per slot

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Type of slot:
Rate: $	Type of slot:
Rate: $	Type of slot:

☑ Price per unit of service

Percent of Clients Served: 100 %
Percent of Expenditures: 100 %

Unit: quarter hour	Rate: $ 13.64
Unit: daily	Rate: $ 6.46
Unit: hourly	Rate: $ 9.83

☐ Per capita allocation (Formula:)

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care

Percent of Clients Served: %
Percent of Expenditures: %

Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:
Rate: $	Diagnostic Group:

Program Performance Monitoring

- [x] On-site inspections

  Frequency for treatment: ANNUALLY

  Frequency for prevention: OTHER as needed

- [x] Activity Reports

  Frequency for treatment: MONTHLY

  Frequency for prevention: MONTHLY

- [x] Management Information System

- [x] Patient/participant data reporting system

  Frequency for treatment: MONTHLY

  Frequency for prevention: MONTHLY

- [x] Performance Contracts

- [x] Cost reports

- [x] Independent Peer Review

- [x] Licensure standards - programs and facilities

  Frequency for treatment: OTHER every three years

  Frequency for prevention: OTHER every three years

- [x] Licensure standards - personnel

  Frequency for treatment: OTHER every three years

  Frequency for prevention: OTHER every three years

Other:

- [ ] Specify:

The monitoring (on-site inspections) of treatment programs will continue to be completed annually. For nationally accredited agencies, this will consist of a billing review with clinical components. An annual Safety and Basic Assurances Review that includes a review of contract, certification, and block grant requirements will be completed for each agency that lacks national accreditation. This process is new for FY 2011 and procedures are still in development.

Form 7

State Priorities

	State Priorities
1	Defend the substance abuse prevention and addiction treatment budgets from further cuts (related to Maintenance of Efforts requirements).
2	Provide for and encourage the use of Medication Assisted Treatment and other evidence-based practices.
3	Ready State for Healthcare Reform and the integration of behavioral healthcare with the broader healthcare system.
4	Improve process for individualized care.
5	Enhance and expand the qualified workforce (related to Goal 11).
6	Make improvements to the state's Substance Abuse Traffic Offender (SATOP) program based on current scientific research and evidence based practices.
7	Maintain an appropriate continuum of substance abuse treatment and support services to achieve the five domains of recovery (related to Goal 1).
8	Convert the remaining traditional addition treatment programs to the CSTAR model (eligible for Medicaid reimbursement).
9	Improve efforts to track capacity management and referral processes (related to Goal 9 and Goal 10).
10	Increase utilization of system data for informed decision-making and to enhance monitoring efforts.
11	Develop and integrate the State's Epidemiology Workgroup into the planning and decision-making process (related to State Prevention Plan and Goal 13).
12	Implement an internal quality improvement program.

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 - 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to fund a continuum of treatment services but, in addition, will promote and support a wider utilization of evidenced-based practices by treatment providers. This will include early intervention services available to contracted providers such as Clinical Outreach, as well as, Behavioral Health Consultation with Report and Motivational.

As a continuation and expansion of work initiated under a grant from the Robert Wood Johnson Foundation that ended in FY 2009, ADA will continue work to identify and remove barriers to the implementation and integration of evidence-based practices (EBP) including medication-assisted services to treat alcohol and opioid dependence, as well as motivational interviewing. Primary Recovery Plus (PR+) contracts do allow billing for a brief motivational intervention prior to the completion of the comprehensive assessment. In FY 2011, the Division will be exploring how to implement this option on CSTAR contracts.

In FY 2009, collaborative partnerships were developed between the Division of ADA, Alkermes Pharmaceuticals, and the Department of Corrections with the goal of increasing the appropriate use of Vivitrol for severe alcohol addiction. ADA will continue to work with Alkermes to connect contracted providers with the training and informational resources this company offers. The Division of ADA and the Department of Corrections will continue to offer mutual consumers the benefit of Vivitrol and other addiction medications when its use is determined to be clinically appropriate. “Change Leaders” conference calls will continue to be offered by the Division and participation by all treatment providers will be encouraged.

The Division of Alcohol and Drug Abuse will continue to administer funding and oversee all community-based substance abuse treatment services for offenders. A Memorandum of Understanding with the Department of Corrections delineates the terms of this collaborative working relationship. The community-based programs for offenders that are managed by ADA include outpatient services throughout the state, Alt-Care and Free and Clean programs in St. Louis and Kansas City, and a Partnership for Community Restoration program in St. Louis.

The Division of ADA will continue to collaborate with SAMHSA, CSAT, and other opioid accrediting bodies to evaluate certified opioid treatment programs. Discussion topics during conference calls will include: current issues in opioid treatment; disaster planning; methadone deaths; drug abuse patterns and trends; accreditation survey scope and practice and accreditation standards and guidelines.

The Division will continue to utilize the internal resources of qualified, credentialed staff members to provide treatment programs technical assistance, training, and support in the utilization of evidence-based practices and professional best practices.

Missouri will continue implementation of its Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, funded by an SBIRT grant from the Substance Abuse and Mental Health Services Administration. The Division of ADA will work with other stakeholders including the Missouri Department of Social Services to make screening and brief intervention services Medicaid reimbursable.

FY 2008 Compliance

During FY 2008, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state based on needs assessments and the availability of qualified care providers. Treatment and support services were delivered via 41 Primary Recovery contracts and 57 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts, which includes three opioid treatment providers. There were 182 contracts issued to providers of recovery support services. This does not represent the actual numbers of providers; changes in contracting procedures inflated this number through duplication and/or contract terminations and initiations.

Clinical Outreach

Many individuals are in need of services but are unaware of this need or are unsure how to access services. The Division of ADA reimburses agencies for providing clinical outreach activities which may include assessment, consultation, coordination, and referral. These activities are directed to individuals who are not enrolled as Division of Alcohol and Drug Abuse consumers; individuals using intravenous drugs; and, ADA consumers living in certain subsidized housing. Specific outreach activities conducted face-to-face by either a qualified substance abuse professional or a community support worker are the following:

- Contacts with staff and consumers of DMH psychiatric hospitals, habilitation centers, and community mental health centers;
- Contacts with child welfare and TANF staff and referrals;
- In-home monitoring and case management for DMH consumers residing in Shelter Care Plus and Section 8 housing;
- Activities directed toward intravenous drug users to promote their engagement in substance abuse treatment; and
- For Women's and Children's Programs, contact staff at medical facilities working with pregnant women (e.g., hospitals, clinics, local health departments, OB/GYN physicians).

Detoxification

Often the first step towards recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of publicly-funded detoxification programs available in Missouri are modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's Purchase of Service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; medications, physician and nursing services specific to medication-assisted treatment. In addition, families can also participate in individual and group codependency counseling.

In FY 2008, there were four different types of CSTAR programs available in Missouri: women and children, adolescent, general population, and opioid. All offer three graduated levels of care. All but the opioid programs offer a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women and Children's Treatment Programs

Substance abuse can affect women differently than men, both physically and psychologically. Specialized CSTAR programs are offered for women and their children with programming that is tailored to this population. Pregnant women and women with children in their care are prioritized populations. The full array of services is available and is individualized to the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment participation. Alternative Care (Alt Care) is a more specialized type of women and children's program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Alt Care is designed specifically for female offenders being released from correctional institutions and those under probationary supervision. There is one program in each of Missouri's two metro areas, St Louis and Kansas City.

CSTAR Adolescent Programs

Adolescent CSTAR programs offer a full continuum of services provided by specially trained staff to consumers 12 to 17 years of age. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in residential settings are offered academic support services to minimize disruptions in their education.

CSTAR General Population Programs

CSTAR General Population programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

CSTAR Opioid Programs

Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines.

Primary Recovery and Primary Recovery Plus (PR+)

Missouri's Primary Recovery programs offer a full continuum services within multiple levels of care, modeled after the CSTAR program. Detoxification services are available to any Missourian in need, but are accessed through the PR+ providers. In FY 2008, three of the providers offer modified medical detoxification services versus social setting detoxification. Missouri's receipt of the Access to Recovery (ATR) grant supported the implementation of the ATR goals into the PR+ programs. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which are on file with the Missouri Secretary of State: http://www.sos.mo.gov/adrules/csr/current/9csr/9c30-3.pdf.

FY 2010 Progress

In FY 2010, the Division of Alcohol and Drug Abuse (ADA) continued to support and monitor a full continuum of substance abuse treatment services throughout the state of Missouri via contracts with private treatment providers. Treatment and support services were delivered via 41 Primary Recovery Plus contracts and 28 Comprehensive Substance Treatment and Rehabilitation (CSTAR) contracts.

All primary recovery programs were converted to the Primary Recovery Plus (PR+) model in FY 2006 under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant were to promote consumer choice of treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity. Recovery supports were intended to help keep consumers engaged in treatment for longer periods of time by addressing issues that may otherwise serve as barriers to treatment completion. There were 103 contracted recovery support providers in FY 2010. An expanded menu of recovery support services was made available which includes re-entry coordination, care coordination, work preparation and pastoral counseling. Missouri was awarded a second ATR grant, which was largely implemented in FY 2008. This award allowed for the continuation of the program objectives, with an increased emphasis on the treatment of methamphetamine-dependent consumers. Missouri was one of seven states recognized in May 2009 during the annual meeting of the ATR II grantees. ADA received special recognition for exceeding two performance targets of the grant – number of people served and follow-up interviews with those individuals. A performance incentive payment was awarded to ADA for exceeding the target for follow-up GPRA interviews. In FY 2010, Missouri applied for the third round of ATR grants and currently is awaiting award announcements.

Both the CSTAR programs and the PR+ programs continue to provide a multi-level system of care with a wide service menu that can be applied to meet consumers' individual needs. All services previously cited were continued in FY 2010. In FY 2009, collaborative partnerships were developed between the Division of ADA, Alkermes Pharmaceuticals, and the Department of Corrections (DOC) with the goal of increasing the appropriate use of Vivitrol for severe alcohol addiction. Research has shown that this form of the medication can be especially useful for individuals at high-risk for relapse and for whom daily medication administration is an obstacle to recovery. The Department of DOC is also fully supportive of the use of other medications for the treatment of alcohol and opioid use disorders. Increasing numbers of providers made agency and practice changes in both FY 2009 and FY 2010 to incorporate the use of Vivitrol, naltrexone, suboxone and other medications in their clinical treatment of alcohol and opioid dependence. Monthly "Change Leaders" conference calls were held to disseminate information, discuss progress, and allow providers to share experiences, problems, and successes associated with the provision of medication-assisted treatment.

Early FY 2009 marked the formal end to the Robert Wood Johnson Foundation (RWJF) grant. The purpose of the grant was to study processes and practices within the state and provider systems that were barriers to the use of evidence-based practices (EBP), and consequently improve those practices to increase the utilization of EBP. The focus of the first project year was the development and implementation of medication-assisted services to treat alcohol dependence. The focus in the second year was increased utilization of motivational interviewing. Walk-through exercises were conducted at the provider and state levels during the implementation planning stage. The ability to provide brief motivational interviewing interventions before completion of the assessment was first started with the grant-participating agencies, but was later expanded to all Primary Recovery Plus providers. Nearly all agencies, grant-participating or not, have made efforts to incorporate what was learned during the grant to their current practices.

In mid-to-late FY 2009, the Division added more options to the continuum of care, based in part on lessons learned in the RWJF grant. The Division created a service category available to all contracted programs “ADA Early Intervention Services,” that allows services consistent with Level 0.5 ASAM early intervention criteria to be provided and reimbursed by DMH/ADA within existing provider allocations. The ADA Early Intervention Services program provides for evaluation, education, and early intervention services for individuals with problems or risk factors related to substance use, but for whom an immediate substance-related disorder cannot be confirmed or immediate admission to clinical treatment is not warranted. The program is intended to offer flexibility to providers in determining the appropriate level of services or course of action when a consumer first presents to the agency and exact treatment needs are not yet known. This first encounter should focus on the consumer and his/her needs vs. whether they will be admitted for treatment.

Services currently available in the ADA Early Intervention program include Behavioral Health Consultation with Report (BHCR) and Motivational Interviewing (MI). BHCR is a face-to-face service utilized to determine whether a substance use problem exists and recommend an appropriate course of action, if applicable. It is not intended to be a routine precursor to clinical treatment. Situations when it is appropriately administered include referrals from Probation and Parole, courts, schools, and other agencies when a written report of findings from a substance abuse professional is needed. MI is a face-to-face service to enhance consumer motivation, establish a therapeutic partnership, and increase engagement in treatment. MI, as a distinct service in this context, *may* be delivered sequentially with BHCR.

The Division of ADA continues to collaborate with SAMHSA, CSAT, the Division of Pharmacological Therapies (DPT), and other opioid accrediting bodies to evaluate certified opioid treatment programs (OTP). Each accrediting body must provide DPT with timely reporting regarding the clinics that are accredited. Discussion topics during conference calls and meetings of accrediting bodies include: consumer safety; best practices and current issues in opioid treatment; disaster planning; methadone deaths;

drug abuse patterns and trends; accreditation survey scope and practice; and accreditation standards and guidelines.

The Clinical Utilization Review Unit, staffed by credentialed professionals, continues to function as a monitoring, consulting, and training unit within ADA to ensure the best consumer care is provided in an appropriate, efficient manner. The Certification Unit is also comprised of credentialed staff and are able to provide on-site technical assistance during monitoring activities.

In FY 2009, Missouri implemented its Missouri Screening, Brief Intervention, and Referral to Treatment (SBIRT) program which is funded by a five year grant from the Substance Abuse and Mental Health Services Administration. There is an emerging body of research and clinical experience that supports the use of the SBIRT model as a set of effective interventions for persons at risk. Missouri sites include Burrell Cox North Emergency Room in Springfield, Missouri; University of Missouri's Hospital Emergency Room and Student Health Center in Columbia, Missouri; Smiley Lane Clinic and Family Health Care Center in Columbia, Missouri; and Grace Hill and Neighborhood Clinics in St. Louis, Missouri. As of August 16, 2010, there have been 18,463 screenings, with 1,285 receiving brief education, 253 receiving brief coaching, and 369 referred for treatment assessment. The 2010 Missouri Department of Mental Health Spring Training Institute provided a workshop on the SBIRT model.

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C.§300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

• **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

• **Education** –This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.

• **Alternatives** –This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.

• **Problem Identification and Referral** –This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

• **Community-based Process** –This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.

• **Environmental** –This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

o ***Universal:*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
o ***Universal Direct. Row 1*** —Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
o ***Universal Indirect. Row 2*** —Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
o ***Selective:*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
o ***Indicated:*** Activities targeted to individuals in high-risk environments, identified as having minimal but

detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. *(Adapted from The Institute of Medicine Model of Prevention)*

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 - FY 2013 Intended Use

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continue to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem (NIDA 1997).

Universal Direct

The Missouri Division of Alcohol and Drug Abuse (ADA) will continue to procure with 11 Regional Support Centers (RSCs) for ongoing technical assistance to the approximate 164 community coalitions comprised of a diverse representation of the community. The community coalitions are located within most of Missouri's 114 sub-state regions throughout the state consisting of approximately 1,640 local volunteers. The RSCs will provide technical assistance to 16 of the 17 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions' sustainability efforts. The RSCs will continue to provide technical assistance on utilization of the Strategic Prevention Framework to the approximate 164 coalitions and the 16 SPFSIG coalitions. The ongoing technical assistance provided during the state fiscal procurement cycle from July 1-June 30 will continue to support capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of plans, and the evaluation of data for outcomes.

The RSCs will continue to use the Missouri Student Survey (MSS) as a tool for the community needs assessment. The biennial MSS will continue to be jointly administered by the Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6th-12 graders attending public school across the state.

During FY 2011-FY 2013, under the direction of ADA, the Statewide Training and Resource Center (STRC) will continue to assemble the Statewide Prevention Training and Resource Network (STRN) consisting of a representative from each of the 11 RSCs. The STRN will meet monthly to plan and coordinate statewide prevention efforts on behalf of ADA and the overall state prevention system.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, will represent 13 public universities located throughout the state. PIP will continue to

utilize the Strategic Prevention Framework model and will continue to create positive change on their college campuses. It is anticipated that over 140,000 students will attend PIP campuses full- time and approximately 6,500 students will be served. As a part of evaluation, PIP will continue to administer the Missouri College Student Health Behavior Survey (MCHBS) at the 13 publically funded universities. Approximately 6,500 students will be surveyed to assist in determining the needs of the campuses and to obtain aggregate statewide data annually.

Universal Indirect

During FY 2011-FY 2013, ADA will continue to provide Universal Indirect prevention through multiple prevention providers. The STRC will continue to respond to requests for prevention. In addition, the eleven Regional Support Centers (RSCs), the University of Missouri, and 164 local coalitions will provide universal indirect services. The approximately 164 volunteer coalitions will continue to recognize national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

Merchant tobacco materials will be developed and distributed by the RSCs during the year to tobacco retailers. The RSCs will continue to conduct one walk-in visit to the state's approximate 6,500 retailer outlets in the spring to distribute education materials and educate on tobacco laws. ADA plans on providing incentives to those RSCs whose coverage area has an 88% or higher non-compliance rate for tobacco sales to youth.

ADA intends to utilize the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who includes ADA and the contractual prevention staff. The Statewide Resource Center will continue to be a member of Community Anti-Drug Coalitions of America (CADCA) and will represent Missouri at national conferences. Under the direction of ADA, the STRC will continue to administer training, development and consultant (TDC) funds to the approximately 164 volunteer coalitions. The STRC will continue to plan for the annual Missouri Statewide Prevention Conference.

Partners in Prevention will continue to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and other drug abuse among Missouri college students through monthly meetings, a statewide conference, and one-day workshops/trainings.

ADA will continue to support the Missouri Youth / Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on addressing underage drinking. MYAA will continue to address the topics of environmental and social policy change during the annual Speak Hard workshop for

youth in Jefferson City. MYAA will continue to distribute brochures, pamphlets, and other materials on underage drinking.

ADA will continue to support the St. Louis Arc in delivering Fetal Alcohol Syndrome (FAS) information, education and promoting awareness to youth aged 12-21 in the St Louis schools. An anticipated 5,100 units of information and promotional materials will be distributed.

ADA will continue to enhance and update a web-based statewide data query system for county and state level data. The system will provide access to the data-sets local coalitions utilize for community need assessments.

Selective

ADA will continue to implement Selective services through the school-based initiative and community-based programming for direct services. CSAP model programs will be implemented through the School-based Prevention and Intervention and Resources Initiative (SPIRIT) in five school districts located throughout the state: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The programs include Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During FY 2011-FY 2013, the SPIRIT initiative will continue to provide CSAP model programs to approximately 6,800 students in grades K-9.

Selective prevention services will continue to be provided through seven community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area known as the Missouri Bootheel. The evidence-based programs and strategies to be implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (9-17), , Too Good For Drugs (11-14), after school mentoring emphasizing bullying prevention (12-14), Life Skills (12-14), faith-based programs specializing in youth substance abuse prevention(12-18), Promoting Responsibility through Education and Preparation (PREP) mentoring program (9-11), Lincoln University Youth Development Kid's Beat(6-18), All Stars(11-14), and How to Cope(18+). Over 62,000 Missourians will be served with these programs.

Selective prevention services will continue to be provided through three statewide providers: the Missouri Alliance of Boys and Girls Club, Leadership Education and Advocacy for the Deaf (L.E.A.D.), and Partners in Prevention (PIP). The Missouri Alliance of Boys and Girls Club will continue to implement SMART Moves and Meth SMART to over 60,000 youth ages 5-18 at 13 sites. L.E.A.D., the statewide provider for deaf and hard of hearing, will continue to provide the Teen Institute for the Deaf to over 1,000 deaf and hard of hearing youth ages 12-17. PIP, consisting of 13 state universities, will continue to implement Community Trials, Brief Alcohol Screening and

Intervention for College Students (BASICS), and SMART to over 6,000 students ages 18-24. During FY 2011-FY 2013, the RSCs may elect to provide direct delivery of prevention services in communities and schools. The evidence-based prevention services delivered by the RSC will be based on the community needs assessment and follow the strategic framework model.

FY 2008 Compliance

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continued to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. (NIDA 1997)

Universal Direct

During the year, ADA procured with 11 Regional Support Centers (RSCs) to provide ongoing technical assistance to 162 community coalitions comprised of a diverse representation of the community. The coalitions were located throughout the state and represented approximately 1,620 local volunteers present in most of Missouri's 114 counties plus the city of St Louis. The ongoing technical assistance to the community coalitions supported capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of plans, and assistance with the evaluation of data for outcomes. In addition, the RSCs provided technical assistance to 18 of the 20 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The technical assistance provided by the RSCs increased the coalitions' information and skills necessary to prevent substance abuse in their community.

The RSC's ongoing technical assistance was evident as one of Missouri's 162 coalitions, Ray County Coalition in Lawson, was selected as a recipient of the 2008 Community Anti-Drug Coalitions of America (CADCA) Got Outcomes! Coalition of Excellence Award. This award is given to coalitions that have successfully fought substance abuse in their communities through implementation of a strategy or set of comprehensive strategies resulting in measurable change.

One tool used by the RSCs for the community needs assessment was the Missouri Student Survey (MSS), supported with Safe and Drug Free School and Communities funds. The MSS was jointly administered by ADA and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public school across the state.

Partners in Prevention (PIP), Missouri's higher education substance abuse consortium, represented 12 public universities located throughout the state. During FY 2008, an estimated 130,000 students attended PIP campuses full-time. PIP administered the Missouri College Student Health Behavior Survey (MCHBS) to over 5400 students.

Results from the survey showed a reduction in the percentage of PIP students who engaged in binge drinking.

Universal Indirect

During FY 2008, ADA procured with multiple prevention providers for universal indirect services to support population-based prevention and environmental strategies. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis responded to requests for prevention materials throughout the state. In addition the eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 162 local coalitions also provided universal indirect services. The broadcast media was utilized and reached four million individuals aged 5-64 years. KidsCast, a radio and web-based program was available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The KidsCast web-site had over 5,000 page reviews. The 162 Missouri registered coalitions recognized national prevention awareness programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

ADA utilized the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who included ADA and the contractual prevention staff. The STRC, a Community Anti-drug Coalitions of America (CADCA) member, represented Missouri at national conferences. Under the direction of ADA, the STRC administered training, development and consultant funds to the approximately 162 coalitions. These resources were supported with the Governor's Discretionary Fund of Safe and Drug Free School and Communities funds.

Merchant tobacco materials were developed and distributed to the RSCs during the annual merchant education campaign held from February through May, 2008. During the campaign, the RSCs informed retailers on the tobacco laws and on the availability of tobacco retailer training for employees. The campaign consisted of a phone call and two walk-in visits to the state's approximate 6,500 retailer outlets. More than 20,000 phone call and walk-in contacts were completed. Several support centers partnered with the Division of Alcohol & Tobacco Control to provide training to retailers in their region.

ADA continued to support the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on addressing underage drinking. MYAA addressed the topics of

environmental and social policy change during the annual Speak Hard workshop for youth held in Jefferson City.

Selective

Selective prevention strategies targeted subsets of Missouri's population that were identified by ADA to be at risk for substance abuse. ADA's selective prevention programs were provided through subgroups which as a whole had higher risk of substance abuse than the general population.

ADA implemented selective services through a school-based program, School-based Prevention, Intervention and Resources Initiative (SPIRIT). CSAP model programs were implemented in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches. The programs included Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2008, the SPIRIT initiative provided CSAP model programs to over 7,300 students in grades K-9.

Selective prevention services were also provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include Creating Lasting Connections, Creating Lasting Family Connections (ages 9-17), Passport to the Future: Urban Rhythms (ages 5-18), Too Good For Drugs (ages 11-14), after school mentoring emphasizing bullying prevention (ages 12-14), Life Skills (ages 12-14), faith-based programs specializing in youth substance abuse prevention (ages 12-18), Promoting Responsibility through Education and Preparation (PREP) mentoring program (ages 9-11), Lincoln University Youth Development Kid's Beat (ages 6-18), All Stars (ages 11-14), and How to Cope (ages 18+). Over 60,000 Missourians were served through these eight agencies.

Selective prevention services were provided through the Missouri Alliance of Boys and Girls Club, consisting of 12 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Club was youth who may be academically failing and low-income. The sites implemented SMART Moves to over 60,000 youth ages 5-18.

ADA also provided selective prevention through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing.

L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. L.E.A.D. provided The Teen Institute for the Deaf to over 1000 youth ages 12-17.

Partners in Prevention (PIP) targets the subgroup of students at risk for underage and binge drinking on college campuses. PIP, consisting of 12 state universities, implemented Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 5,800 students ages 18-24.

Indicated

The SPIRIT initiative also implemented Reconnecting Youth to students in grades 10-12 at Carthage and Knox County serving over 50 students. The students served through SPIRIT's Reconnecting Youth exhibited risk factors such as conduct disorders, and alienation from parents, school, and positive peer groups.

References:

National Institute of Drug Abuse (1997). "Drug Abuse Prevention: What Works", pp. 10-15.

FY 2010 Progress

Universal

The Missouri Division of Alcohol and Drug Abuse (ADA) utilizes Universal prevention strategies to address Missouri's entire population (state, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Missouri's ADA Universal prevention programs continue to focus on the mission of universal prevention, to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. (NIDA 1997)

Universal Direct

The Missouri Division of Alcohol and Drug Abuse (ADA) continues to procure with 11 Regional Support Centers (RSCs) for ongoing technical assistance to 164 community coalitions comprised of a diverse representation of the community. The community coalitions are present in most of Missouri's 114 counties plus the city of St Louis and involve approximately 1,640 local volunteers. The RSCs also provide technical assistance to 16 of the 17 Strategic Prevention Framework State Incentive Grant (SPFSIG) coalitions. The ongoing technical assistance continues to support capacity building at the local level through community needs assessments, resource identification, development of community plans to address the identified needs, implementation of the plans, and the evaluation of data for outcomes. The technical assistance provided by the RSCs continues to increase the coalition's information and skills necessary to prevent substance abuse.

The RSCs continue to use the Safe and Drug Free School and Communities funded Missouri Student Survey (MSS) as a tool for the community needs assessment. The biennial MSS is jointly administered by the Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) and the Missouri Department of Elementary and Secondary Education (DESE) to assess substance use and related behaviors among 6^{th}-12^{th} graders attending public schools across the state. The RSC monthly progress with each coalition is monitored by ADA prevention specialists.

Missouri's higher education substance abuse consortium, Partners in Prevention (PIP), has a membership of 13 public universities. PIP continues to utilize the Strategic Prevention Framework and strives to create positive change on their college campuses. The technical assistance provided by PIP to the 13 college campuses continues to increase information and skills necessary to prevent substance abuse. Full-time enrollment for PIP schools is over 130,000 students. During the year, PIP administered the Missouri College Student Health Behavior Survey (MCHBS) at the 13 publically

funded universities. Over 6,500 students participated in the survey designed to assist in determining the needs of the campuses and obtain aggregate statewide data.

Universal Indirect

ADA continues to provide Universal Indirect to support population-based prevention through multiple prevention providers. Three Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis responds to requests for materials. In addition, the eleven Regional Support Centers (RSC), the Statewide Training and Resource Center (STRC), the University of Missouri, and 164 local coalitions provide universal indirect services. The broadcast media are utilized to reach about 4 million individuals aged 5-64 years. KidsCast, a radio and web-based program continues to be available for Missouri youth in 4^{th}-6^{th} grades to increase awareness of how tobacco, alcohol, drug use and unhealthy behaviors impact communities. The KidsCast website receives approximately 5,000 page reviews annually. The 164 volunteer coalitions recognizes national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3D Month, and Alcohol Awareness Month.

Merchant tobacco materials continue to be developed and distributed to the RSCs during the annual merchant education campaign. During the campaign, the RSCs inform retailers on tobacco laws and the availability of tobacco retailer training for employees. The campaign consists of a walk-in contact conducted during March 2010 with the state's approximate 6,500 retailer outlets. Several RSCs partner with the Division of Alcohol & Tobacco Control to provide training to retailers in their region. ADA provided incentives to those RSCs whose coverage area has an 88% or higher non-compliance rate for tobacco sales to youth.

ADA uses the Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the substance abuse prevention workforce who includes ADA and the contractual prevention staff. The STRC, a member of Community Anti-Drug Coalitions of America (CADCA), represents Missouri at national conferences. Under the direction of ADA, the STRC continues to administer training, development and consultant resources to the 164 Missouri registered coalitions.

Under the direction of ADA, the STRC serves as the coordinating member for the Statewide Prevention Resource and Training Network (SPTRN) consisting of a representative from each of the RSCs. The SPTRN plans and coordinates statewide prevention efforts on behalf of ADA and the overall state prevention system.

Partners in Prevention continues to provide on-going training opportunities for higher education professionals, law enforcement, judicial officers, and students on effective prevention efforts of alcohol and other drug abuse among Missouri college students

through monthly meetings, a statewide conference, and one-day workshops/trainings. About 380 higher education professionals, law enforcement, judicial officers, and students attended the statewide conference, Meeting of the Minds, held April 8-10, 2010 in Kansas City. PIP's continued efforts to reduce binge drinking on Missouri campuses was recognized during the February 2010 presentation of the 2009 Coalition in Focus Award from Community Anti-Drug Coalition of America (CADCA).

ADA continues to support the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and educational opportunities to local community efforts focused on addressing underage drinking. MYAA addresses the topics of environmental and social policy change during the annual Speak Hard workshop for youth in Jefferson City. MYAA also distributes brochures, pamphlets, and other materials on underage drinking.

ADA supports the St. Louis Arc in delivering Fetal Alcohol Syndrome (FAS) information, education and promoting awareness to youth aged 12-21 in St Louis schools. Over 4,200 information and promotional materials have been distributed during the year. In addition, 945 informational and promotional materials have been distributed through health fairs, conferences, and a town hall meeting.

Selective

Selective prevention strategies targets subsets of Missouri's population that were identified by ADA to be at risk for substance abuse. ADA's selective prevention programs are provided through subgroups which as a whole had higher risk of substance abuse than the general population.

ADA continues to provide selective services through the school-based program, School-based Prevention Intervention and Resources Initiative (SPIRIT). CSAP model programs have been implemented in five school districts: Knox County, Carthage, Hickman Mills, New Madrid, and Ritenour. The school districts participating in SPIRIT were identified as high-risk districts based on the number of youth for each district, the number of referrals to juvenile authorities, school drop-out rates, and the number of students receiving reduced or free lunches. The programs include Peace Builders, Second Step, Project Towards No Drug Abuse, Life Skills and Too Good For Drugs. During 2010, SPIRIT has served over 9,400 students in grades K-9.

Selective prevention services are being provided through eight community-based agencies located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the Missouri Bootheel. The subgroups targeted by these community-based agencies include youth who are experiencing academic failure located in communities identified as low income. The evidence-based programs and strategies implemented by these agencies include

Creating Lasting Connections, Creating Lasting Family Connections (age 9-17), Passport to the Future: Urban Rhythms (age 5-18), Too Good For Drugs (age 11-14), after school mentoring emphasizing bullying prevention (age 12-14), Life Skills (age 12-14), faith-based programs specializing in youth substance abuse prevention (age 12-18), Promoting Responsibility through Education and Preparation (PREP) program (age 9-11), Lincoln University Youth Development Kid's Beat (age 6-18), All Stars (age 11-14), and How to Cope (age 18+). During the year, approximately 62,000 Missourians have been served with these programs.

Selective prevention services continue to be provided through the Missouri Alliance of Boys and Girls Club, consisting of 13 Boys and Girls Club sites located throughout the state. The target subgroup for the Missouri Alliance of Boys and Girls Club is youth who may be academically failing and low-income. During the year, the 13 Boys and Girls Club sites have provided SMART Moves and Meth-SMART to over 60,000 youth ages 5-18.

ADA continues to provide selective prevention through the Leadership Education and Advocacy for the Deaf (L.E.A.D.), the statewide provider for Deaf and Hard of Hearing. L.E.A.D. targets the subgroup of Deaf and Hard of Hearing youth in Missouri. During the year, L.E.A.D. has provided The Teen Institute for the Deaf to over 1,000 youth ages 12-17.

ADA continues to provide selective prevention to the subgroup of students at risk for underage and binge drinking on college campuses through Partners in Prevention (PIP). PIP, consisting of 13 state universities, has provided Community Trials, Brief Alcohol Screening and Intervention for College Students (BASICS), and SMART to over 6,000 students ages 18-24 during FY 2010.

ADA continues to enhance the web-based statewide data query system for county and state level data. The system provides access to the data-sets local coalitions utilize for community need assessments.

Indicated

ADA did not fund Indicated evidence-based programs during FY 2010. Reconnecting Youth (RY), previously funded in two of the SPIRIT sites was discontinued due to teacher certification requirements for provider staff implementing RY in the school sites.

References:

National Institute of Drug Abuse (1997). "Drug Abuse Prevention: What Works", pp. 10-15.

Goal #3: Providing specialized services for pregnant women and women with dependent children

An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services (See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Division of Alcohol and Drug Abuse will continue to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority, as well as quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. For nationally accredited agencies, this will consist of a billing review with clinical components. An annual Safety and Basic Assurances Review that includes a review of contract, certification, and block grant requirements will be completed for each agency that lacks national accreditation. This process is new for FY 2011 and procedures are still in development. A certification survey of program practices and operations conducted by a team of treatment specialists will be completed every three years for such agencies. The Division will be developing internal monitoring procedures using data obtained from CIMOR. These reports will offer additional information that can help inform billing reviews, SBARs, or focused reviews for accredited and non-accredited programs alike. Programs also regularly communicate with the Division's Area Treatment Coordinators which assists the Division in determining compliance with standards, as well as contract and block grant requirements.

FY 2008 Compliance

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. CSTAR programs allow women and their children to receive multiple levels of care based upon their assessed needs. Specialized Women and Children's CSTAR programs are available in each region of the state, in both rural and urban settings. ADA maintained certification standards that prioritize the treatment of pregnant or postpartum women or women with dependent children. During FY 2008, 324 pregnant women entered treatment upon request at specialized CSTAR program and received prenatal care and referrals in accordance with the requirements in the CSTAR certification standards and contract requirements. However, due to geographical restraints or other issues, pregnant women sometimes receive services at other types of CSTAR programs or Primary Recovery treatment agencies. They and their specific needs are priorities for all contracted treatment providers. In total, 582 pregnant women were admitted to ADA-contracted treatment programs

Nurses are available at each Women and Children's CSTAR agency to assist with medical needs and referrals. Community support workers assist consumers with coordinating social service needs identified during the assessment process. Childcare is provided on-site or the program makes arrangements for child care at licensed facilities.

Contract monitoring has occurred annually through Safety and Basic Assurance Reviews at each agency. The monitoring visit included the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with requirements. Certification surveys have occurred on a three-year cycle and included a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. During FY 2008, monitoring schedules were maintained.

FY 2010 Progress

The Division of Alcohol and Drug Abuse continues to provide specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services for pregnant women and women with dependent children. There are 12 Women and Children CSTAR contracts with services delivered by 11 different provider agencies. In FY 2010, 344 pregnant women have been admitted to one of these specialized CSTAR programs. However, due to geographical or other issues, many pregnant women may choose to receive services elsewhere. In total, 657 pregnant women were admitted to the Division's contracted treatment programs this fiscal year. Evidence-based treatments, including trauma-informed care and services, and co-occurring services continue to be available in these programs.

The Division developed contract language to more specifically address expectations regarding the admission of priority populations. An amendment for Women and Children's CSTAR programs was issued at the start of FY 2010 that more clearly identified the prenatal and supportive services that must be provided or arranged for to meet SAPT Block Grant requirements. This language is as follows:

The contractor shall comply with the following federal requirements for its Women and Children's CSTAR program:

a. *The contractor shall provide or arrange for the provision of services specified below for pregnant women, and women with dependent children, including women who are attempting to regain custody of their children:*
    1) *Primary medical care for women, including referral for prenatal care and child care while the women are receiving treatment service;*
    2) *Primary pediatric care, including immunization, for their children;*
    3) *Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, parenting and child care;*
    4) *Therapeutic interventions for children in custody of women in treatment which may include, but are not limited to, addressing their developmental needs and issues of sexual and/or physical abuse or neglect; and*
    5) *Sufficient case management and transportation to ensure women and their children have access to needed services.*

All treatment providers had their contracts amended at the start of FY 2010 that clearly designated the Division's priority populations and how their admissions were to be managed. The priority population amendment is as follows:

1. *In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*

2. *The Department has identified two groups of priority populations for substance abuse treatment:*

   a. *Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:*

      - *Women who are pregnant.*
      - *Intravenous (IV) drug users who have injected drugs in the prior 30 days. May be referred for immediate admission to an opioid treatment program, if safe and clinically appropriate.*
      - *Civil involuntary commitments. Ninety-six hour commitments must be admitted to detoxification services in PR+ or Enhanced PR+ programs. Thirty-day commitments must be admitted to detoxification or to Level 1 with residential support.*

   b. *Priority II populations: Priority II populations may require admission to detoxification or residential support when in crisis, but otherwise an appointment must be scheduled to occur within two weeks of first contact, followed by treatment at the appropriate level of care. Priority II populations include:*

      - *Post-partum women (up to six months after delivery).*
      - *Women with dependent children under 13 in their physical care and custody.*
      - *Families in the child welfare and TANF systems.*
      - *Offenders being released from Department of Corrections' institutions.*
      - *Offenders given priority for admission by the Division of Probation and Parole (via referral form and protocol).*
      - *Adolescents and families served through the Children's System of Care.*

3. *For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.*
4. *In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.*
5. *The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.*

Nurses continue to be available at each Women and Children's CSTAR agency to assist with medical needs and referrals. Community support workers assist consumers

with coordinating social service needs identified during the assessment process. Childcare is provided on-site or the programs make arrangements for child care at licensed facilities.

In FY 2010, the Department of Mental Health redesigned its information system screens and data tables for the collection of the Treatment Episode Dataset (TEDS) data. The modifications went into production in May 2010. Included in this redesign is the additional collection of birth data for pregnant women, as well as data on child custody. At admission, the new screens collect pregnancy status for female consumers and number of children removed from custody for all consumers. At discharge, the new screens collect the number of children returned to parental custody, the number of live births for pregnant female consumers, the number of those births that were drug-free, and the reason for drug exposure if births were not drug-free. Data integrity is improved by collecting the data within the information system using built-in business rules. Previously collected manually only for the CSTAR Women and Children's programs, this data is now collected for all ADA programs and will allow the Division to better monitor outcomes for pregnant women and women with children.

Contract monitoring occurred this year through Safety and Basic Assurance Reviews (SBAR) at each agency, unless the agency was due for a full certification survey. The SBAR monitoring visit included the Area Treatment Coordinator reviewing the program's practices and the Block Grant Requirement Checklist to ensure compliance with requirements. Certification surveys occur on a three-year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare.

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?

3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

FY 2008 Programs for Pregnant Women and Women with Dependent Children

Treatment for women in the State of Missouri has been enhanced over the past twenty years due in part to the support of Block Grant funds. The Missouri Department of Mental Health – Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender-integrated programs to creating programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs represent a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the programs provide for licensed daycare services for the children accompanying their mothers to treatment, either through the direct operation of daycare services or by arranging daycare services in a community setting. The dependent children receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addictions. In this manner, the mandate of Section 1922(c) in spending FY 2008 Block Grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request for ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific population, assisting them with recovery in any life domain negatively impacted by substance use. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured, intensive treatment in the continuum of care, and is provided in a trauma-sensitive environment. Services are provided five to seven days per week. Services available include day treatment (group and individual counseling, group education, and structured recovery support activities), community support, family therapy, trauma counseling, co-occurring disorders counseling, medication and professional medical services for medication-assisted treatment, residential support and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation:
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intensive level of treatment are transitioned into this level of care to provide opportunities for them to interact within their

families and community while continuing to receive an intermediate level of support and treatment. Services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are offered each week. Treatment is provided in a trauma-sensitive environment and consists of a menu of services including group counseling and education, individual counseling, community support, family therapy, trauma counseling, co-occurring disorders counseling, professional medical services and medication to support medication-assisted treatment, and day care for dependent children. Age-appropriate assessment and codependency counseling are provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, offering a minimum of three therapeutic activities weekly. Women who are assessed as not needing intensive or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Alternately, women who have completed a more intensive level of treatment may be transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma-sensitive environment and consists of a menu of services including all of those listed under Community-based Primary Treatment and Intensive Outpatient Rehabilitation.

Specialized Treatment

Specialized CSTAR programs for Women and Children must address therapeutic issues that are relevant to women, addressing their specific needs. These issues shall include, but are not limited to parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. Group counseling is offered to allow consumers to explore emotional issues and work towards healthy self image, relationships, and lifestyles. Individual counseling allows for further exploration of issues and to promote the development of individualized treatment goals. Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma, mental health education, and relapse prevention.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State certification standards require each program to be licensed as a daycare facility for children unless an exception is granted. If they cannot provide childcare on-site, services must be arranged through a licensed day care facility. A child therapist must be on staff in each program to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless may receive housing assistance from ADA while participating actively in treatment. Supportive housing is intended as a bridge to other, long-term housing arrangements. Two forms of housing support currently available through the treatment providers are community housing and transitional housing. Community Housing may be provided to consumers and their families who are in need of a living arrangement that supports ongoing recovery and community integration. Community Housing may be provided in an individual apartment or single-family home of the consumer's choice that is inspected and approved by the Department. The stipend for community housing can be used to pay rent, initial deposits, utilities and local telephone service. Transitional Housing may be provided to consumers in need of a living arrangement that provides an intermediate level of supervision, structure and external support for their continued recovery. Transitional Housing is provided in a communal living setting limited to sixteen adult beds, inspected and approved by the Department. Transitional Housing funds provide for room and board and on-site supervision when consumers are present.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses offer medical services, referrals, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The community support workers assist the consumers in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors enable the provision of prenatal care, immunizations and other preventive measures to increase the well-being of mothers and their children. All CSTAR programs conduct a communicable diseases risk assessment for all consumers at admission. Pre- and post-test counseling for HIV/AIDS, sexually transmitted diseases and tuberculosis are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

In FY 2007, a specialized communication protocol was developed to facilitate communication between primary care physicians (PCP), case managers for the Medicaid managed care plans, Women and Children CSTAR providers, and ADA's Clinical Utilization Review Unit. The protocol provides guidelines for the communication of all parties should the women enter the system given a variety of different referral sources. This will ensure pregnant women and their child will have access to all available treatment and support services that meet their specialized clinical needs. The protocol was continued in FY 2008 and expanded to include all Women and Children's CSTAR programs. Initially, only those within the MO HealthNet managed care service areas were included. It was soon realized that some women must seek services outside of their service network and the Division wanted to promote communication with all potential providers.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY 2008, 6,515 women and children were treated in the

CSTAR women and children programs. In FY 2008, 89 of 97 babies born to women in these specialized CSTAR programs were born drug-free. In addition, 110 children were returned to their mother's custody from the Children's Division because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost-effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized, outcome-based system of monitoring consumer improvement in numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on-going goals.

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of General Revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary consumers and 10 beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All of the women's' facilities have access to supportive housing funds, and therefore can offer additional safe housing options.

Women and children served in FY 2008 at the women's programs are provided by level of care and agency:

Agency	collateral	non-collateral		
		short-term residential	intensive outpatient	non-intensive outpatient
Alternative Opportunities, Inc.	100	302	263	152
BASIC	45	0	208	50
Bridgeway Behavioral Health, Inc.	83	535	260	90
Comprehensive Mental Health Services	59	250	186	99
Family Counseling Center	36	400	273	83
Family Counseling Center of Missouri, Inc.	137	252	236	179
Family Self Help Center	148	230	237	61
Hannibal Council On Alcohol & Drug Abuse	94	277	114	51
New Beginnings Cstar	0	0	355	126
Queen Of Peace Center	183	339	635	301
ReDiscover	374	292	640	234

A list of all women and children's CSTAR programs in Missouri, including the sub-State

Planning Area (SPA) and the Inventory of Substance Abuse Treatment Services (I-SATS) ID number, is as follows:

Black Alcohol/Drug Service Information Center (BASIC)
3026 Locust
St. Louis, MO 63103
Allocated funds FY 2008 $587,945
Number of beds: 0
SPA: Eastern Region
ISATS: MO903788

Bridgeway Behavioral Health, Inc.
1570 South Main Street
St. Charles, MO 63303
Allocated funds FY 2008 $944,310
SPA: Eastern Region
Number of beds: 16 for women and 10 for children
ISATS: MO100786

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2008 $796,863
SPA: Central Region
Number of beds: 16 for women and 5 for children
ISATS: MO902269

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63701
Allocated funds FY 2008 $815,888
SPA: Southeastern Region
Number of beds: 16 residential; can accommodate children
ISATS: MO101128

Family Self-Help Center
Lafayette House Serenity Program
PO Box 1765, 1809 Connor Avenue
Joplin, MO 64804
Allocated funds FY 2008 $690,285
SPA: Southwestern Region
Number of beds: 16 for women and 10 for children
ISATS: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2008 $709,494
SPA: Central Region
Number of beds: 16 for women and 10 for children
ISATS: MO750098

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65801-1277
Allocated funds FY 2008 $696,306
SPA: Southwestern Region
Number of beds: 16 for women and 12 for children
ISATS: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2008 $914,006
SPA: Eastern Region
Number of beds: 0
ISATS: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2008 $914,006
SPA: Eastern Region
Number of beds: 16 for women and 10 for children
ISATS: MO100591

Comprehensive Mental Health Services (CMHS)
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2008 $864,097
SPA: Northwestern Region
Number of beds: 16 for women and 10 for children
NFR ID: MO301678

ReDiscover
(Two programs: Alt-Care women's Correctional and a Women and Children Program)
620 East 18th Street
Kansas City, MO 64108

Allocated funds FY 2008 Women and Children $854,759
Number of beds: 11 for women and 6 for children (age < 12)
Allocated funds FY 2008 Alt-Care Women's Correctional $936,105
Number of beds: 0
SPA: Northwestern Region
ISATS: MO101207

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2008 Block Grant funds?

Treatment services for women in the State of Missouri have continued to expand due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve provider contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Two of the CSTAR programs were designed in collaboration with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. Dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. A site certification survey is conducted at all CSTAR treatment program every three years by a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance abuse treatment. In addition, Area Treatment Coordinators perform annual Safety and Basic Assurances Reviews (SBARs) which include a review of compliance with Block Grant requirements. The Area Treatment Coordinators also provide technical assistance when necessary. Representatives from each women and children's program meet regularly to collaborate with ADA staff on developing issues and trends.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, the number of consumers, and consumer demographics (including pregnancy at admission). Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document

was developed to assist ADA in placement of new CSTAR Women and Children's programs as funds became available.

5. What did the State do with FY 2008 Block Grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in Women and Children's CSTAR Programs has increased from 2,548 in FY 1995 to 6,515 in FY 2008.

At the start of FY 2007, ADA expanded the service menu to include two new service codes related to treating trauma issues in the context of substance abuse issues. Trauma Individual Counseling and Trauma Group Education would be of immediate benefit to many of the women engaged in services at contracted substance abuse treatment providers, thereby enhancing the service array in existing programs. The service codes were made available on all ADA treatment contracts. These services continued in FY 2008.

Also in FY 2007, ADA implemented a protocol in coordination with the Division of Social Services (MO HealthNet) and the CSTAR Women and Children providers that focuses on facilitating substance abuse treatment referrals for pregnant women who are recipients of MO HealthNet Managed Care benefit. This protocol reinforced the prioritization of pregnant women into treatment. In FY 2008, MO HealthNet and ADA continued to collaborate to ensure that MO Healthnet enrolled pregnant women and women with dependent children have ready access to substance abuse treatment services.

Goal #4: Services to intravenous drug abusers

An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. §300x-23 and 45 C.F.R. §96.126).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-13 (Intended Use)

The Division has contractual language that more explicitly states requirements for serving priority populations. Intravenous drug users (IVDUs) are identified as a priority population for whom admission must be immediate. Given that requirement, the Division's expectations are more stringent than SAPT Block Grant requirements. Compliance with this contractual requirement will be monitored during certification surveys that occur on a three-year cycle as well as during Safety and Basic Assurance Reviews (SBARs) that occur in the interim years. If there are significant issues related to compliance with the immediate admission requirement, a plan of correction will be requested from providers. Additionally, the Division has language in contracts that specifically requires IVDUs to be included in agency outreach activities.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

FY 2008 Compliance

The capacity management systems in operation in FY 2008 for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

The contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant." Opioid treatment providers were required to admit or refer individuals who abused

intravenous drugs within the past thirty days or were in imminent danger of relapse. The Customer Information Management, Outcomes and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health, has a waiting list function which can be used in lieu of program enrollment. Once treatment becomes available, the consumer can then be transferred from the waiting list to a program admission.

Provider contracts include provisions and requirements related to outreach activities. Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the certification survey process and annual Safety and Basic Assurance Reviews which includes the Block Grant Requirement Checklist.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

FY 2010 (Progress)

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards. Standards require that each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed. Additionally, the contracts for the Primary Recovery Plus (PR+) programs include specific language informing them that part of the program funding comes from the SAPT Block Grant and is therefore "subject to the federal rules and regulations associated with that grant." To more specifically ensure the prompt evaluation and treatment of intravenous drug users (IVDUs), the Division developed new contract language at the end of FY 2009 that identifies IVDUs as a priority population. The language requires the immediate admission of individuals in this population, as noted in the following:

> In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations. The Department has identified two groups of priority populations for substance abuse treatment:
>
> a. Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:
>
> 1. Women who are pregnant;
> 2. Intravenous (IV) drug users who have injected drugs in the prior 30 days. May be referred for immediate admission to an opioid treatment program, if safe and clinically appropriate; and
> 3. Civil involuntary commitments. Ninety-six hour commitments must be admitted to detoxification services in PR+ or Enhanced PR+ programs. Thirty-day commitments must be admitted to detoxification or to Level 1 with residential support.
>
> b. Priority II populations: Priority II populations may require admission to detoxification or residential support *when in crisis*, but otherwise an appointment must be scheduled to occur within two weeks of first contact, followed by treatment at the appropriate level of care. Priority II populations include:
>
> 1. Post-partum women (up to six months after delivery);
> 2. Women with dependent children under 13 in their physical care and custody;
> 3. Families in the child welfare and TANF systems;
> 4. Offenders being released from Department of Corrections' institutions;
> 5. Offenders given priority for admission by the Division of Probation and Parole *(via referral form and protocol); and*

6. Adolescents and families served through the Children's System of Care.

For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.

Opioid treatment providers are required to admit or refer individuals who abuse intravenous drugs within the prior thirty days and are in imminent danger of relapse. The Customer Information Management, Outcomes and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health, has a waiting list option which can be used in lieu of program enrollment. Once treatment becomes available, the consumer can then be transferred from the waiting list to a program admission. This allows ADA providers who choose to use this function to track priority population consumers who are waiting for treatment. In FY 2010, 6,310 consumers identified as IVDUs were admitted to substance abuse treatment.

Provider contracts include provisions and requirements related to outreach activities. In FY 2010, contracts were amended to clearly identify IVDUs as a population to be targeted in outreach activities. This language is as follows:

Clinical Outreach

The contractor may provide clinical outreach services for certain persons including:

- individuals who are not enrolled as Division of Alcohol and Drug Abuse consumers;
- individuals using intravenous drugs; and
- ADA consumers living in certain subsidized housing.

Clinical Outreach activities may include assessment, consultation, coordination, and referral. Clinical outreach activities shall be limited to:

- Contacts with staff and consumers of DMH psychiatric hospitals, habilitation centers, and community mental health centers;
- Contacts with child welfare and TANF staff and referrals;
- In-home monitoring and case management for DMH consumers residing in Shelter Care Plus and Section 8 housing;
- activities directed toward intravenous drug users to promote their engagement in substance abuse treatment; and
- for Women & Children Programs, contact staff at medical facilities working with pregnant women (e.g., hospitals, clinics, local health departments, OB/GYN physicians).

Additionally, ADA encourages each provider to maintain contact with those consumers on their waiting list by providing interim services, including linkage to other appropriate services and community resources, until treatment services at the appropriate intensity

are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. ADA can also assist agencies in locating referral resources throughout the state. Compliance with block grant requirements has been consistently monitored through the Certification Survey process and annual Safety and Basic Assurances Reviews which includes the Block Grant Requirement Checklist.

ADA continues to use certification surveys and annual Safety and Basic Assurances Reviews with the Block Grant Checklist to review provider compliance with priority treatment for IVDUs. Agencies found to be out of compliance are identified and are required to provide an action plan to achieve contract and standard compliance. Technical assistance, consultation, and focused compliance reviews are applied to those treatment agencies serving IVDUs to ensure consistent compliance and the provision of high quality service to the high-risk IV drug abusing consumer.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011.

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

See 42 U.S.C. §300x-23; 45 C.F.R. §96.126; and 45 C.F.R. §96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).

3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).

4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

FY 2008 Programs for Intravenous Drug Users (IVDUs)

1. Missouri defines intravenous (IV) drug abusers as those substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously, intramuscularly, or subcutaneous injection.

2. Throughout FY 2008, all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs. Providers are contractually mandated to adhere to Block Grant requirements. While no official notification of reaching 90% capacity was formally sent to the Division of Alcohol and Drug Abuse (ADA), programs do communicate with staff at the Division's district offices via phone and/or email regarding their capacity when issues arise or when information or referral assistance is requested. At points during which capacity was reached, programs made referrals to other resources in the community, for example, to other contracted providers, private pay opioid, or detoxification programs. The Customer Information, Management, Outcomes and Reporting (CIMOR) information system for the Missouri Department of Mental Health (DMH) has a waiting list function which may be used. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurance Reviews (SBARs). Agency admissions of priority populations, including IV drug users, and management of waiting lists are discussed and monitored during certification and SBAR visits, as well as, during technical assistance visits that might be conducted throughout the year. Regional staff conducting these reviews are knowledgeable about contract requirements and how to apply them to substance abuse treatment programs. Programs demonstrate compliance with capacity requirements by either conducting a brief screening by telephone or in person with the consumer. At that time, an assessment/admission date for individuals requesting service is scheduled or an appropriate referral for alternative or interim services is provided to the consumer.

   The agencies that provided treatment services to IVDUs in FY 2008 are listed as follows:

Organization Name	ISATS ID
Alternative Opportunities, Inc.	MO101560
Assessment & Counseling Solutions	MO100687
BASIC	MO903788
Bridgeway Behavioral Health, Inc.	MO100786
Burrell Behavioral Health Care Center	MO902004
Center For Life Solutions, Inc.	MO301603

Organization Name	ISATS ID
Clark Community Mental Health Center	MO101631
Community Mental Health Consultants	MO100930
Community Services of Missouri, Inc.	MO102035
Community Treatment, Inc.	MO901592
Comprehensive Mental Health Services	MO100518
Cox Health Systems, Inc.	MO903515
E.S.C.A.P.E. Outpatient Chemical Dependency Center	MO103868
Eastern Mo Alternative Sentencing Services, Inc.	MO101623
Family Counseling Center	MO903598
Family Counseling Center of Missouri, Inc.	MO750056
Family Guidance Center	MO101532
Family Self Help Center	MO101029
Gibson Recovery Center, Inc.	MO903911
Hannibal Council On Alcohol & Drug Abuse	MO750098
Kansas City Community Center	MO301785
Liberty Programs Inc., The	MO101490
Meramec Recovery Center, Inc.	MO102027
Midwest ADP, Inc.	MO102068
Missouri Alcohol Assessment Consultants	MO101987
New Beginnings Cstar	MO102928
Northland Dependency Services, LLC	MO101755
Paseo Clinic	MO100667
Pathways Community Behavioral Healthcare, Inc.	MO901527
Phoenix Programs, Inc.	MO102159
Preferred Family Healthcare, Inc.	MO101797
Queen Of Peace Center	MO100591
ReDiscover	MO100864
Salvation Army - Harbor Light Center	MO101033
Samuel U Rodgers Health Center	MO100716
Scott Greening Center For Youth Dependency	MO100922
Sigma House of Springfield	MO750593
Southeast Missouri Behavioral Health, Inc.	MO903259
Swope Health Services	MO106598
Tri-County Mental Health Services	MO105152
Westend Clinic	MO105087

At the end of FY 2009, contract language was added to make IV drug users a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users

may be referred for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contracts were further modified to indicate:

a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

3. Opioid treatment providers were required to admit persons, within the Block Grant required time frames, who have used IV drugs within the prior 30 days, are pregnant, have HIV, or who were in imminent danger of relapse. If at capacity, programs were to make referrals to other resources in the community, for example, to private pay opioid programs or detoxification programs. The information system designed and maintained by DMH has waiting list functionality. ADA has encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. Compliance with Block Grant regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during certification surveys and Safety and Basic Assurances Reviews.

   At the end of FY 2009, contract language was added to make IV drug users a priority I population for all treatment programs. As a priority I population, IV drug users who have injected drugs in the prior 30 days require immediate admission to detoxification or residential support unless clinically contraindicated. IV drug users may be referred for immediate admission to an Opioid treatment program if safe and clinically appropriate. Contracts were further modified to indicate:

   a. For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.
   b. In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.

   In FY 2009, a new data field was added to the CIMOR information system to capture *Date of First Contact.* In FY 2010, ADA began sending providers monthly summary reports of days waiting for treatment. In addition, the Division developed an on-

demand report in CIMOR that allows providers to view days waiting for treatment for admitted consumers. The Division continues to develop monitoring reports to identify consumers that indicated IV drug use and were not admitted within the required timeframe.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

4. ADA has encouraged certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address intravenous (IV) drug use. Outreach requirements were specified in provider contracts. As outreach services are billable, documentation is required to reflect the description of the outreach activity. Contract language specifies:

    a. The contractor may provide clinical outreach services for certain persons including individuals using intravenous drugs. For IVDUs, outreach activities are to promote their engagement in substance abuse treatment.
    b. Clinical Outreach activities may include assessment, consultation, coordination, and referral.
    c. Clinical outreach services shall be provided on a face-to-face basis.
    d. The contractor shall maintain a log for clinical outreach service provided that includes, at a minimum, the following information:
        i. Date of service
        ii. Actual time
        iii. Name of consumer/person
        iv. Referral source
        v. Name and title of staff providing the services
        vi. Description of the outreach activity; and
        vii. Outcome or disposition.
    e. Contractor staff providing this service shall be qualified substance abuse professionals or community support workers, as defined in certification standards.

    Contract compliance is one of the areas monitored by regional staff during Safety and Basic Assurance Reviews (SBARs). Providers are encouraged during certification surveys to engage consumers' families in treatment and to address family IV drug use. ADA collaborates with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood-borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA collaborates with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug

abuse. Individual providers offer presentations specific to IV drug use to local probation, parole, drug, and mental health courts personnel.

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. §300x-23(a); 42 U.S.C. §300x-24(a); and 42 U.S.C. §300x-27(b).

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

• A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. §300x-23(a)
(See 45 C.F.R. §96.126(f) and 45 C.F.R. §96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. §96.127(b) and 45 C.F.R. §96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. §300x-27(b)
(See 45 C.F.R. §96.131(f) and 45 C.F.R. §96.122(f)(3)(vii)).

FY 2009 Program Compliance Monitoring

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly-funded system of care continue to remain at or near capacity. Regional monitoring procedures are in place to assist consumers in accessing treatment as quickly as possible. ADA has a toll-free number advertised to consumers for providing treatment referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area. Agency activity levels are monitored at the regional level through the Regional District Administrators and Area Treatment Coordinators (ATCs). Regional District Administrators and ATCs meet with providers on an as-needed basis to discuss issues pertaining to access, capacity, referral processes, and other treatment issues. As noted, ATCs and District Administrators regularly take calls from consumers attempting to access care at local providers. As consumers are assisted with obtaining a referral, regional ADA staff obtain real-time feedback about capacity and access issues at the providers in their regions. ATCs also conduct yearly Safety and Basic Assurance Reviews at each provider in their respective regions. Every three years, the ADA Certification team conducts comprehensive surveys. Compliance with certification standards is assessed. While always an issue of importance, the Division of ADA is beginning to focus very specifically on how agencies provide a continuum of care to consumers. This includes how the agency provides for all levels of care needed and/or how the agency works with other agencies to provide a full range of services at varying intensities.

Agencies within close proximity of each other have also developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. In addition, ADA assists agencies in locating treatment services throughout the state. Again, assessing a provider's capacity to provide or arrange for a full continuum of care will assist in monitoring for access and capacity issues.

The Customer Information Management, Outcomes, and Reporting (CIMOR) system, designed and maintained by the Missouri Department of Mental Health (DMH), provides a wait list function. CIMOR is accessible to all the organizations that have contracts with the Division of Alcohol and Drug Abuse (ADA). ADA encourages each provider to maintain contact with those consumers on their waiting lists by providing interim treatment services until services at the appropriate level of care are available and/or providing referrals for adjunct or supportive services.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

No specific problems were identified with agencies managing capacities and thus, no corrective action was taken.

2. Tuberculosis Services

ADA collaborates with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA requires contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided include educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services are provided to determine whether the individual has been infected with mycobacterial tuberculosis. Those testing positive receive referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide access to tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities are required to maintain collaborative relationships with their county health departments. Consumers may have access to testing and health care services at any time during their treatment. Agencies may not deny access to treatment based on a positive tuberculosis test result providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment providers may request assistance from county health department staff to observe their consumers taking preventive medicine when a positive tuberculosis skin test is identified.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the consumer, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control, in determining appropriate services and available medical resources.

Training and education opportunities are available to provider staff through DMH and DHSS. The Division's treatment specialists, District Administrators, and Area Treatment Coordinators continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site certification surveys, Safety and Basic Assurances Reviews, and technical assistance visits, ADA monitors tuberculosis services including screening, referral, testing procedure, counseling, and consumer confidentiality. Certification surveys are conducted every three years. Safety and Basic Assurance Reviews are conducted during the years in which certification is not performed. Technical assistance visits are provided as needed. Providers' billings of pre- and post-test counseling services can be determined through CIMOR and associated reporting programs.

The infection control recommendations and protocols for substance abuse treatment providers include, but are not limited to, the following procedures:

- screening of patients,
- identifying those individuals who are at high risk of becoming infected, and
- complying with all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems related to tuberculosis services were identified and thus, no corrective action was taken.

3. Treatment Services for Pregnant Women

It has been a long-standing Division of Alcohol and Drug Abuse (ADA) policy that service providers must give priority to pregnant women seeking admission to treatment. Certification standards mandate this for programs specializing in women's treatment. ADA maintains the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer these services to women and children suffering from the effects of substance abuse. CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. These programs are available in each region of the state. ADA has maintained certification standards which establish substance abusing pregnant or postpartum women or women with custody of children as a first priority population. CSTAR certification standards (9 CSR 30-3.190 Specialized Program for Women and Children) state that "[p]riority shall be given to women who are pregnant or postpartum" and, "[t]he program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria."

To further ensure all treatment programs understand the prioritization of pregnant women, new contract language in FY 2010 clearly identifies pregnant women as a treatment population for whom admission must be immediate. To further specify block grant requirements for those programs specializing in the treatment of women, a contract amendment was issued that outlines the services that must be provided or arranged for pregnant women and women with dependent children.

During FY 2009, 652 pregnant women entered Missouri's substance abuse treatment system upon request and received prenatal care and referrals in accordance with the requirements certification standards and contracts. In FY 2010, there were 657 pregnant women were admitted to substance abuse treatment services.

Contract monitoring occurs annually through Safety and Basic Assurances Reviews at the program site. This review includes the Area Treatment Coordinator reviewing the program's practices and Block Grant Requirement Checklist to ensure compliance. Certification surveys occur on a three-year cycle and include a review to ensure

pregnant women are receiving first priority for services, pregnant women are receiving prenatal care, and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance.

As no problems were noted, no corrective actions were taken.

Goal #5: TB Services

An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring: Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to make tuberculosis (TB) risk assessment, testing, and risk reduction education available to all treatment consumers. All substance abuse treatment programs will continue to conduct general health screens upon admission to identify high risks consumers and to offer TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and services for TB may be arranged upon request from the consumer. Testing and other services will be provided by the local health clinic with a referral from the substance abuse treatment program. The provision of tuberculosis-specific services will continue to be monitored with annual Safety and Basic Assurances Reviews and certification site surveys. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that consumers will have access to and can participate in tuberculosis services. This requirement is established in contracts. Contracted providers will continue to receive ADA support, technical assistance, and direct intervention at the community level to access TB services. ADA will continue to offer technical assistance to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services (DHSS) community health departments. The DHSS will continue to serve as a repository for statistical data and as an information and training resource related to tuberculosis issues.

ADA will continue to make available continuing education for providers through future trainings at the DMH Spring Training Institute. Continued collaboration with the Department of Corrections will increase awareness of TB and other communicable diseases that are tested and treated within the prison substance abuse programs and to providers who treat individuals supervised by Missouri's Division of Probation and Parole. ADA continues to work with providers to develop recovery plans that will decrease the number of consumers who would potentially become high-risk for TB and other communicable diseases because of homelessness or sheltered living.

FY 2008 Compliance

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services (DHSS) to access current information, trends, and training related to the prevention and treatment of tuberculosis in high risk groups. The DHSS serves as a repository for statistical data and as an information and training resource related to tuberculosis (TB) issues. There is a Memorandum of Understanding between ADA and DHSS with the purpose of combining "skills, experience, and expertise for the development of a collaborative educational effort designed to benefit the general public and those at high risk for health and mental health conditions." This collaborative effort is to provide for an integrated systems framework by which both entities will educate, through technical assistance, local providers contracted with ADA to provide substance abuse counseling services, in order to better serve the consumers. ADA has a representative who has attended Community Planning Group meetings that address a variety of issues related to communicable diseases. The ADA representative has disseminated information to providers as it relates to TB services, information, and issues.

ADA has required contracted treatment providers to make TB skin testing available to all consumers in their programs. Health screening is a best practice utilized upon admission and thereafter during treatment, as needed, to identify those consumers who might be considered at risk for transmitting *M. tuberculosis* or who might be infected. Consumers may request TB testing and/or counseling. Treatment providers are also required to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. This requirement was and is formalized, along with requirements for other communicable diseases, in contract language as follows:

> ***Communicable Diseases Risk Assessment, Education, Testing and Counseling***
>
> 1. *The contractor shall have a working relationship with the local health department, physician, or other qualified healthcare provider in the community to provide any necessary testing services for Human Immunodeficiency Virus (HIV), tuberculosis (TB), sexually transmitted diseases (STDs), and Hepatitis.*
>
>   a. *The contractor shall arrange for HIV, TB, STDs and Hepatitis testing to be available to the consumer at any time during the course of the consumer's treatment.*
>
>   1) *The contractor shall make referrals and cooperate with appropriate entities to ensure coordinated treatment, as appropriate, is provided for any consumers with positive tests.*
>
> 2. *The contractor shall provide or arrange individual counseling for consumers prior to testing for HIV.*

a. In the event the contractor elects to provide HIV pre-test counseling, counseling shall be provided in accordance with the State of Missouri Department of Health and Senior Services (DHSS) Rule (19 CSR 20-26.030), as mandated by state law. These requirements may be downloaded from the following site:

http://www.sos.mo.gov/adrules/csr/current/19csr/19c20-26.pdf

b. Contractor staff providing HIV pre-test counseling must be trained in accordance with DHSS requirements. The contractor shall be responsible for all costs associated with receiving any such training.

3. The contractor shall provide or arrange individual post-test counseling for consumers who test positive for HIV or TB.

a. Contractor staff providing post-test counseling must be knowledgeable about additional services and care coordination available through the DHSS.

4. The contractor shall arrange and coordinate, as necessary, post-test follow-up for consumers who test positive for STDs or Hepatitis.

5. The contractor shall provide group education with substance abusers and/or significant others of abusers to discuss risk reduction and the myths and facts about HIV/TB/STD/Hepatitis and the risk factors for contracting these disease.

Compliance with TB and other communicable disease-related requirements was and is assessed as part of annual Safety and Basic Assurance Reviews (SBARs), at certification surveys, and at accreditation surveys for Missouri's Opioid treatment programs. This requirement is specifically included on the tool used to conduct SBARs. The SBAR process involves interviewing provider staff about these requirements and discussing established community linkages. As screening for communicable diseases is a requirement of intake assessments, information about one's risk status can be found in chart reviews during both SBARs and certification visits. Information is also screened by ADA through clinical reviews that are electronically processed through the Department of Mental Health's Customer Information Management Outcomes and Reporting (CIMOR) system. Chart reviews focus on how a consumer has been provided, or has had access arranged for, a full continuum of care, including medical and health-related services.

FY 2010 Progress

Contracted treatment providers are required to make tuberculosis (TB) skin testing available to all consumers in their programs. Consumers are assessed through the screening and/or assessment process to identify specific health concerns; such as outcomes of previous TB testing, exposure to TB, or if the consumer is asymptomatic because of latent tuberculosis infection (LTBI). Consumers who are considered to be at high risk (HIV infected or IV users) or have other risks identified above are offered testing. Consumers may also request testing. All substance abuse treatment programs provide TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. Providers are required by contract to maintain effective linkages with local health departments to assist treatment program staff with consumer testing and monitoring efforts. TB post-test counseling funding is available as part of the Access to Recovery grant.

Compliance with TB and other communicable disease-related requirements was and is assessed as part of annual Safety and Basic Assurance Reviews (SBARs), at certification surveys, and at accreditation surveys for Missouri's Opioid treatment programs. This requirement is specifically included on the tool used to conduct SBARs. The SBAR process involves interviewing provider staff about these requirements and discussing established community linkages. As screening for communicable diseases is a requirement of intake assessments, information about one's risk status can be found in chart reviews during both SBARs and certification visits. Providers are required to chart information regarding a consumer's TB and other communicable disease-related status through the Department of Mental Health's Customer Information Management Outcomes and Reporting (CIMOR) system. The information is available for clinical reviews conducted by ADA staff. Chart reviews focus on how a consumer has been provided, or has had access arranged for, a full continuum of care, including medical and health-related services. ADA provides a linkage between providers and the Missouri Department of Health and Senior Services (DHSS) when referrals and training opportunities are needed, particularly in rural settings. The ADA representative has met with DHSS' TB Coordinator to review the CDC's "Guidelines and Recommendations for Preventing the Transmission of *M. tuberculosis* in HealthCare Settings." This review analyzed the risk level of and needed precautions for substance abuse treatment settings and staff at the facilities.

The Missouri DHSS, as part of a Memorandum of Understanding with the Division of Alcohol and Drug Abuse (ADA), offers technical assistance and direct intervention at the community level to contracted providers to procure TB testing supplies. The Memorandum has been modified from a yearly agreement and is now extended to five years. ADA participation in Community Planning meetings continue with collaboration as to the risk of substance abuse and risk behaviors of the gay, lesbian, bisexual, transgender communities of Missouri. The DHSS continues to provide follow-up diagnostic services for consumers who do not have health care resources. The DHSS

has demonstrated their commitment to the provision of consistent TB services at the community level. This state department serves as a repository for statistical data and as an information and training resource related to tuberculosis issues.

Goal #6: HIV Services

An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128).

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011- FY 2013 Intended Use

Missouri is not a designated state.

FY 2008 Compliance

Missouri was not a designated state.

FY 2010 Progress

Missouri is not a designated state.

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

• development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
• the role of the Single State Agency (SSA) for substance abuse prevention and treatment; and
• the role of the Single State Agency for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

• the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
• the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
• the linkages between IVDU outreach (See 42 U.S.C. §300x-23(b) and 45 C.F.R. §96.126(e)) and the projects delivering early intervention services for HIV; and
• technical assistance.

FY 2008 Tuberculosis (TB) and Early Intervention Services for HIV

Note: Missouri is not an HIV designated state.

The Division of Alcohol and Drug Abuse (ADA) has provided tuberculosis (TB) and human immunodeficiency virus (HIV) services in the four publicly-funded methadone programs and other selected treatment programs since 1989. Linkages between early intervention services for HIV and the Intravenous Drug Users (IVDU) Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993, all substance abuse treatment programs have provided TB and HIV services to consumers entering treatment by arranging with a nearby health clinic to provide consumers with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. In FY 2010 $38,857 of total state funds and $10,610 of federal funds were spent on TB services for clients who were in substance abuse treatment – for total TB expenditures of $49,467.

During FY 2010 $555 was spent on TB tests by Department of Health and Senior Services (DHSS). All consumers, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the DHSS, local county health departments, and substance abuse programs to ensure services are available to all consumers.

In FY 2010 these services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. All consumers received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre-and post-test counseling, testing, and HIV education were available to consumers in substance abuse treatment. A total of $30,255 was spent on TB pre-and post-test counseling.

A Treatment Specialist from ADA maintained regular contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided by the Department of Mental Health in the form of technical assistance and consultation. ADA adhered to the protocols established by the Centers for Disease Control and Prevention (CDC) and DHSS.

All offenders receiving substance abuse treatment within the Missouri Department of Corrections (DOC) receive TB testing with a two-step test at intake. This is performed and read by licensed nurses. Patient education is also provided. Testing is performed annually in the birth month or if a consumer is symptomatic or is exposed to an active case. Those who are symptomatic or have positive tests/x-rays/sputum are isolated in

respiratory isolation. They remain there until TB is ruled out or until treatment is proven successful by negative sputum tests. Those with a positive test, indicating exposure, but without active disease, are given prophylactic treatment directly observed by nursing staff. Those with active disease are given medication and housed in respiratory isolation until no longer contagious. Those exposed to active cases are tested. All positive tests are reported to DHSS. If an active case is identified DOC works with the DHSS to develop an action plan. A total of $8,047 was spent by DOC on the above TB services.

The responsibility for public health and communicable diseases is a secondary role for the Division, but requires close coordination of policy and program priorities between DHSS and ADA. ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies the on-going partnership related to the prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to, and utilization of, HIV prevention and care services, sexually transmitted diseases (STD), Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and regional cross-training are available for delivery to all regions in the state as identified in the current MOU between DHSS and ADA.

Goal #7: Development of Group Homes

An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. §300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

At the beginning of FY 2011, the Division of Alcohol and Drug Abuse (ADA) terminated its contract with Oxford House, Inc. as the result of dwindling resources at ADA and a deficiency in the revolving loan balance that conflicts with the statutory requirement of at least a $100,000 balance. The Division of ADA will opt out of maintaining group homes through a revolving loan fund. The remaining balance of the revolving loan will be re-allocated to fund substance abuse services.

FY 2008 Compliance

Since 2002, the state of Missouri contracts with Oxford House, Inc. to manage the Revolving Loan Fund to provide start-up costs for safe, stable housing for individuals in recovery. To be accepted in an Oxford House, the individual in recovery completes and submits an application to a House. Members of the House review the applications, interview applicants, and determine through a democratic vote who to accept into the House. House members must maintain sobriety. A return to substance use results in automatic expulsion. Individuals accepted into an Oxford House must attend self-help groups such as AA during the first 30 days of acceptance and are encouraged to attend on a regular basis thereafter. In addition, individuals accepted into an Oxford House must obtain employment within 30 days of acceptance if not already employed or on disability. If the individual is on disability, the individual must also be attending school or engaging in at least 20 hours of community service per week.

Each house elects officers that generally include a president, treasurer, secretary, comptroller, and coordinator. The treasurer and comptroller are responsible for the House's money management. Regular House meetings are held to discuss the House's financial status as well as other issues impacting the House and its members. Each House member is responsible for paying an equal share of the household expenses as well as contributing to the household chores. Household expenses include rent for the House and utilities. The lease for the House is established between the landlord and the House members. The Division of Alcohol and Drug Abuse (ADA) housing specialists work to educate landlords on the Oxford House program and to find landlords willing to rent their property as an Oxford House.

The Oxford Houses form chapters. The state's 53 Oxford Houses in operation in FY 2008 were represented by 6 chapters. The chapters engage in public relations activities to inform individuals and groups about the Oxford House program. This includes monthly presentations at substance abuse treatment centers to individuals who may be in need of stable housing once treatment has been completed. The chapters also meet to discuss issues faced by member Houses. ADA housing specialists provide consultation to chapters and individual houses on various issues including, but not limited to, financial management and relationship issues – making referrals as needed. In addition, ADA housing specialists work with Houses to attract new members to fill vacancies. It is not uncommon, however, for Houses to have waiting lists. ADA housing specialists receive and monitor regular loan payment reports from Oxford House, Inc. Technical assistance from the ADA Drug Free Group Home Specialist is provided to Houses falling behind in their financial commitments.

In FY 2008, Missouri had 53 Oxford Houses located in 9 cities. The 41 houses for men provided 336 beds. The 12 houses for women provided 98 beds. The one house for veterans provided 8 beds. Two (2) new houses were opened in FY 2008 and refinancing was made to six (6) existing houses. Most of the state's Oxford Houses are located in cities of sufficient size to support the needed membership. This included the Kansas City area in the Western part of the state, the St Louis area in the Eastern part

of the state, Columbia in the Central part of the state, and Springfield in the Southwestern part of the state. Some Houses were also located in smaller towns including Winfield, Joplin, Cape Girardeau, St Joseph, Festus and St. Charles. In FY 2008, stable and affordable housing remained a significant need for many Missourians entering recovery.

FY 2010 Progress

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), continues to support the Oxford House program within the state of Missouri. The Oxford House program offers a supportive way of living for individuals in recovery to learn and implement skills needed for long-term recovery in a clean, sober and safe environment. All Oxford Houses have three characteristics in common:

- Houses are democratically self-run;
- House membership is responsible for all household expenses; and
- Houses must immediately expel any member using alcohol or drugs.

Missouri has 55 Oxford Houses – 42 for men with a total of 353 beds, 12 for women with a total of 90 beds, and 1 house for veterans with a total of 8 beds. Houses have been established in every region of the state but with the greatest representation in the more heavily populated areas of Kansas City and St Louis.

At the start of FY 2010, there was $21,991.26 in the revolving loan account. Six new loans totaling $17,000 and 2 stabilization loans totaling $7,000 have been given over the course of the fiscal year. As the loans are paid back, more loans are taken out to open new houses.

During FY 2010, the Division currently had one housing specialist to provide technical assistance to the Oxford House program. This housing specialist provided

- consultation to Oxford House chapters on fundraising activities to replenish the revolving loan fund so that new Houses can be established,
- referrals for individuals seeking housing,
- guidance to House membership on financial management and inter-personal conflict resolution, and
- education on the Oxford House program for concerned parties.

In January 2010, the State contacted Oxford House Inc. to seek an explanation for the revolving loan fund balance being below $100,000 as required by SAPT Block Grant requirements. Oxford House Inc. responded to the Division's inquiry in February 2010. Oxford House Inc. indicated that since inception the Missouri Recovery Home Revolving Loan fund has loaned more than $300,000 to start new Oxford Houses. Over the last seven years repayments have been made by Oxford Houses and the chapters at a rate of 73%. Over the last several years, the loan has been slow to replenish due to an increase in the number of houses closing.

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year;

• the source of funds used to establish and maintain the revolving fund;

• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;

• the private, nonprofit entity selected to manage the fund;

• any written agreement that may exist between the State and the managing entity;

• how the State monitors fund and loan operations; and

• any changes from previous years' operations.

FY 2008 Group Home Entities and Programs

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States initially were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25 penalty if not received as scheduled.

There were five (5) loans issued in FY 2008 totaling $14,800.00. The amount of funds available as of July 1, 2008 was $29,651.55. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received. There have been instances of late payments or loan defaults during the past year due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching from a women to men's houses. In FY 2008, 25 loans were outstanding totaling $53,236.00. Twelve loans were in default totaling $34,270.00. When payment issues arise, a letter is sent to the house reminding them of their payment obligations. In cases where a house closes, the loan is reassigned to the Oxford House Chapter or another house until the loan is repaid.

On a monthly basis, the Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the Department of Mental Health, Division of Alcohol and Drug Abuse (ADA). Technical assistance is provided by the Drug Free Group Home Specialist and can be obtained through a toll-free phone number. Through publications, meetings, and workshops, ADA has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2008, 113 loans have been committed in Missouri for drug-free group homes. These homes are located in 15 Missouri cities. More than $336,205.00 has been loaned to open Oxford Houses in Missouri since 1989. There are 55 houses in the state where 361 men and 90 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

List of group homes:

Central Region			
Bicknell **104 Bicknell** **Columbia, MO 65203** **M 573-442-7084**	**Calico** **2504 Calico St.** **Columbia, MO 65202** **M 573-474-0035**	**Cougar** **1810 Garth** **Columbia, MO 65202** **M 442-2330**	**Countryside** **2504 Quail Dr.** **Columbia, MO 65203** **M 573-219-9716**
Hubbell **1700 Countryside Lane** **Columbia, MO 65202** **W 573-219-9597**	**Leslie** **19 E. Leslie** **Columbia, MO 65202** **M 573-256-5221**	**Leslie** **19 E. Leslie** **Columbia, MO 65202** **M 573-256-5221**	**Proctor** **314 Proctor Dr.** **Columbia, MO 65202** **M 573-874-9610**
Sondra **921 Sondra** **Columbia, MO 65202** **M 573-875-5721**	**W/ Broadway** **2402 W. Broadway** **Columbia, MO 65203** **W 573-514-4310**	**Willowbrook** **2501 Willowbrook** **Columbia, MO 65202** **M 573-474-0741**	

Eastern Region			
Allendale **3127 Meramec** **St. Louis, MO 63118** **M 314-353-5823**	**Chippewa** **6408 Chippewa** **St, Louis, MO 63109** **V 314-353-2771**	**Clayton** **6957 Clayton Rd.** **St. Louis, MO 63117** **M 314-863-7669**	**Fairview** **2171 Hwy. 61** **Festus, MO 63028** **M 636-937-2514**
Gravois **3943 Gravois** **St. Louis, MO 63116** **M 314-772-1303**	**Humphrey** **3542 Humphrey** **St. Louis, MO 63118** **M 314-762-9976** **314-762-9794**	**Jarman** **4506 S. Grand** **St. Louis, MO 63118** **W 314-351-1567**	**Kensington** **5058 Kensington** **St. Louis, MO 63108** **M 314-367-7962**
Lincoln-Midwest **1663 Lincoln Dr.** **St. Charles, MO 63303** **M 636-493-1385**	**Lynncove** **1751 Lynncove Lane** **St. Charles, MO 63303** **M 636-724-4562**	**Lusher** **11876 Lusher Rd.** **St. Louis, MO 63138** **M 314-741-7536**	**McCausland** **2017 McCausland** **St. Louis, MO 63143** **M 314-644-0971**
McDonough **527 McDonough** **St. Charles, MO 63301** **M 636-947-6730**	**Michigan** **7127 Michigan** **St. Louis, MO 63111** **M 314-351-2712**	**Monitor** **3633 Meramec** **St. Louis, MO 63116** **W 314-752-1213**	**Montana** **3655 Montana** **St. Louis, MO 63116** **M 314-351-2064**
Oak Lake **4004 Ashby Rd.** **St. Louis, MO 63047** **W 314-432-5514**	**Osage** **2715 Osage** **St. Louis, MO 63118** **W 314-7726771**	**Portis** **4430 Arsenal** **St. Louis, MO 63116** **M 314-776-5825** **314-776-7076**	**Raymond** **1376 Trampe** **St. Louis, MO 63138** **V 314-653-653-6544**
S. Pacific **540 S. Pacific** **Cape Girardeau, MO 63703** **W 573-651-4646**	**St. Charles** **1047 Washington** **St. Charles, MO 63303** **M 636-493-1751**	**Shenandoah** **720 Shenandoah** **St. Louis, MO 63104** **M 314-776-4883**	**South Jefferson** **827 Jefferson** **Cape Girardeau, MO 63703** **M 573-651-6066**
Winfield **60 Franke Dr.** **Winfield, MO 63389** **M 636-566-6258**			
Western Region			
Blue Hills **1832 E. 49th St.** **Kansas City, MO 64130** **M 816-923-7696**	**Chouteau** **4401 N Walrond Ave.** **Kansas City, MO 64117** **M 816-632-9851**	**Harrison** **26 E. Concord** **Kansas City, MO 64112** **M 816-216-1883**	**Hillcrest** **9615 Freemont** **Kansas City, MO 64134** **M 816-761-3948**
Holmes **2641 Holmes** **Kansas City, MO 64108** **M 816-842-1634**	**KC Crossroads** **1832 Washington** **Kansas City, MO 64108** **W 816-569-1345**	**Karnes** **3734 Walnut** **Kansas City, MO 64111** **W 816-232-4773**	**Marlboro** **1410 E 77th Terrace** **Kansas City, MO 64131** **M 816-333-2267**
Raytown **10905 E. 62nd Terrace** **Raytown, MO 64133** **M 816-358-6495**	**Rockhill** **5632 Charlotte** **Kansas City, MO 64108** **W 816-569-2325**		

Northwestern Region			
Felix **1419 Felix** **St. Joseph, MO 64501** **M 417-232-4773**	**Museum** **1210 Felix** **St. Joseph, MO 64501** **M 816-689-3825**	**St. Joseph** **507 S. 10th Street** **St. Joseph, MO 65401** **M 816-232-8988**	**Truman** **400 S. Hocker** **Independence, MO 64050** **M 816-833-0222**
Southwestern Region			
Catalina **1674 S. Catalina** **Springfield, MO 65804** **M 417-887-7783**	**Kerr** **953 W. Kerr** **Springfield, MO 65803** **M 417-368-9199**	**Moffett** **529 Moffet** **Joplin, MO 64801** **M 417-623-4347**	**United** **1558 W. Cherokee** **Springfield, MO 65807** **M 417-887-7783**
Technical Assistance Staff			
1-800-575-7480 ADA Toll Free Number			
Jacquie Lockett **5400 Arsenal MSA-419** **St. Louis, MO 63139** **(314) 877-0386** **jacqueline.lockett@dmh.mo.gov** **Oxfordhousemo.gov**			**M = Men** **W = Women** **V=Veterans**

Goal #8: Tobacco Products

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. §300x-26, 45 C.F.R. §96.130 and 45 C.F.R. §96.122(d)).

• Is the State's FY 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)

• If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

Missouri plans to submit the FFY 2011 Annual Synar Report with the FFY 2011 SAPT Block Grant application.

Goal #9: Pregnant Women Preferences

An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. §300x-27 and 45 C.F.R. §96.131).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. New contract language was incorporated at the start of FY 2010 that clearly relays the expectations for all contracted providers regarding the prioritization of pregnant women. Specifically, pregnant women are to be immediately admitted to substance abuse treatment services when they present or are referred for care. Compliance will continue to be monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

The Division of Alcohol and Drug Abuse (ADA) will continue its participation in and promotion of the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. The protocol guides collaboration and communication between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services. The ADA Clinical Utilization Review Unit will continue to monitor referrals to CSTAR treatment programs through the protocol and promote communication between the primary care providers and health plan case managers. The unit will continue to submit quarterly reports to the MO HealthNet Division on the progress of the protocol.

FY 2008 Compliance

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) provides specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given priority admission. Monitoring procedures were in place to assist pregnant women in accessing treatment as quickly as possible. Agency admission practices were monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by DMH includes a waiting list function in addition to the regular program admission function. ADA encouraged each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care became available. Agencies within close proximity of each other developed informal telephone communications to refer consumers to other programs when they were unable to meet the needs of those consumers seeking treatment. In addition, ADA assisted agencies in locating treatment services throughout the state. ADA had a toll-free number advertised for consumers to call for referrals. Central office or regional staff received the calls and made referrals to treatment programs in the consumer's area. Compliance was monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

FY 2010 Progress

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. This priority status was reinforced with revised contract language at the outset of FY 2010. This language is as follows:

1. *In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*
2. *The Department has identified two groups of priority populations for substance abuse treatment:*
    a. *Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:*
        - *Women who are pregnant…*
3. *For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.*
4. *In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.*
5. *The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.*

Compliance continues to be monitored by certification surveys and annual Safety and Basic Assurances Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district office staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required

At the start of FY 2008 the Division of Alcohol and Drug Abuse (ADA) implemented a protocol to facilitate the referral of pregnant women in Medicaid Managed Care in need of substance abuse treatment to Women and Children's Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. This protocol is formally known as the Substance Abuse Treatment Referral Protocol for Pregnant Women under MO HealthNet Managed Care. The protocol guides the collaboration and communication between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services. The ADA Clinical Utilization Review Unit monitors referral to CSTAR treatment programs through the protocol and promotes communication between the primary care providers and

health plan case managers. In FY 2009, reports were developed using data from the Customer Information Management, Outcomes and Reporting (CIMOR) system that allowed for the verification of reported admissions. These reports also enabled the Division to more proactively follow-up with providers who were not timely in their reporting of admissions per the protocol. There was more regular communication occurring between the Division and the Women and Children's CSTAR providers this fiscal year. Providers were more receptive to consultation and were provided education about the protocol expectations and benefits. One component of the protocol is the expectation that the CSTAR providers involve primary care providers and health plan case managers in the pregnant women's continuing care plans. The Clinical Utilization Review Unit submits quarterly reports to the MO HealthNet Division.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. The Division of ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. §96.126(c) and 45 C.F.R. §96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:
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• development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

• the role of the Single State Agency (SSA) for substance abuse prevention and treatment;

• the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

• the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

• how interim services are made available to individuals awaiting admission to treatment ;

• the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

• technical assistance.

FY 2009 Capacity Management and Waiting List Systems

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

Capacity management processes for the Division of Alcohol and Drug Abuse (ADA) are addressed in certification standards which guide providers of ADA treatment services. These certification standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.

2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.

3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;

2. Shall be responsive to the individual's request and needs; and

3. *Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.*

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires *(A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services…*

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program…

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the ADA conduct clinical review to "*promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."*

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires *"the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."*

Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. Also, ADA assists agencies in locating referral resources throughout the state.

The certification standards are part of the ongoing operations of ADA. In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information System

DMH implemented a new information system, Customer Information Management, Outcomes, and Reporting (CIMOR), at the beginning of October 2006, which offers all organizations the option of using a tool in this system to manage waiting lists. This is available for access to all the organizations that have contracts with ADA. Providers are encouraged by ADA to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available.

The CIMOR system is a component of the DMH's consumer information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number and ADA Website

ADA has a toll-free number advertised for consumers to call to obtain referral information. Either central office or regional staff receive the calls and offer referrals to treatment programs in the consumer's area. In addition, ADA maintains a website, which provides the public with information regarding substance use and links to treatment facilities.

4. Contractual Requirements

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users (IVDUs). When members of these priority populations present for services, they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs.

This priority status was reinforced with revised contract language at the outset of FY 2010. This language is as follows:

1. *In accordance with the requirements of the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959), Missouri state statute, and Department priorities, the contractor shall give preference for admission to certain identified populations.*
2. *The Department has identified two groups of priority populations for substance abuse treatment:*
    a. *Priority I populations: Priority I populations require immediate admission to detoxification or residential support unless clinically contraindicated. Priority I populations include:*
        - *Women who are pregnant.*

- *Intravenous (IV) drug users who have injected drugs in the prior 30 days. May be referred for immediate admission to an opioid treatment program, if safe and clinically appropriate…*

3. *For all priority populations, the contractor shall respond promptly to requests for consultation, screening, and coordination of care.*
4. *In order to provide immediate admission for priority populations, the contractor understands and agrees that clinically stable consumers may require transfer to a less intensive level of care.*
5. *The contractor shall refer pregnant women to a Women and Children's CSTAR program unless the contractor's treatment team determines that the individual's needs are best met in the contractor's treatment program, and there is clear justification in the clinical record for such determination.*

The prior policy had worked reasonably well in light of limited resources, but the contract language formalizes the Division's expectations. Compliance with this policy will be monitored by certification surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

In FY 2010, ADA requested and was granted technical assistance from the Center for Substance Abuse Treatment (CSAT) regarding the issues of capacity management and wait list. That technical assistance is scheduled to occur in FY 2011. ADA will be reviewing its processes and procedures for tracking capacity management and admissions of priority populations.

Goal #10: Process for Referring

An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. §300x-28(a) and 45 C.F.R. §96.132(a)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

Contracted providers of substance abuse services will continue to use the Assessment Severity Index (ASI) for adults and the Global Assessment of Individual Needs (GAIN) for adolescents. Training and maintenance support of the GAIN assessment will be delivered by contracted treatment providers and the Division of Alcohol and Drug Abuse (ADA) GAIN-certified local trainers as needed. The Division continues to support providers who choose to use the ASI-MV, an interactive, self-administered, computer-based version of the ASI.

ADA will continue to review utilization data to identify practices related to consumer level of care placement and patterns of success by provider. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data are being collected to meet the federal requirements.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation is incorporated into the CIMOR system. All clinical treatment providers are required to collect and enter Treatment Episode Dataset (TEDS) data into the CIMOR system at appropriate points through the consumers' episodes of care. Treatment effectiveness is measured using the National Outcomes Measures (NOMs) domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery. On demand reports are being developed in the CIMOR system that will allow providers to view their program outcomes in comparison to statewide program outcomes. These reports are expected to be available in early FY 2011.

The clinical utilization review unit will continue to review authorization requests and associated assessments for compliance with certification standards, appropriateness of placements in the continuum of care, and acceptable standards of care. This unit will regularly collect provider-specific and service category-specific data on trends in authorization requests.

The Division of ADA has made increasingly clear the expectations that contracted providers deliver highly individualized services to consumers, providing them what they need: no more, no less. This requires a comprehensive assessment and a thoughtful, well-developed treatment plan. It requires a person-centered approach and openness to using evidence-based treatment approaches and interventions. ADA places great emphasis on the importance of attending to the recovery domains of abstinence, stable housing, employment/education, social connectedness, reduced legal problems, and increased retention in treatment. Providers' demonstrations of individualized service design and delivery (or lack thereof) will become important factors in the coming years when certification decisions are made. Providers who are not offering a full spectrum of evidenced-based practices and utilizing a variety of these interventions differentially with consumers may be in jeopardy of losing their certification, and thus contracts, with the

Division of ADA. Technical support and training will be available to those providers that need assistance in modernizing their treatment systems. The Division will continue to maintain high expectations for providers, assisting them in reducing barriers that may impede their progress in meeting these goals.

FY 2008 (Compliance)

The Addiction Severity Index (ASI) was the primary assessment tool used to determine level of care for consumers age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the consumer's admission. This assessment tool encompasses seven areas of life functioning: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status. Since October 2006, the assessment has been available on the Customer Information Management, Outcomes and Reporting (CIMOR) system.

Beginning FY 2007, adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs were required to utilize the Global Appraisal of Individual Needs (GAIN). The GAIN is an evidence-based full bio-psychosocial assessment that is valid in many different treatment settings. It integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN has eight core sections: Background, Substance Use, Physical Health, Risk Behaviors and Disease Prevention, Mental and Emotional Health, Environment and Living Situation, Legal and Vocational. The GAIN provides a comprehensive, standardized tool with which to ensure appropriate consumer placement and service referrals.

ADA staff reviewed assessment and utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers utilized the computerized assessment tool in combination with clinical judgment to assure consumers were provided the most appropriate level of care. The tools used in the assessment process provided the ability to perform utilization review and outcome measurement.

Assessment results should help guide assignment to an appropriate level of care. In addition to Division guidelines on level assignment using assessment information, certification standards outline eligibility requirements for admission into each level of the continuum of care:

9 CSR 30-3.120 Detoxification…

(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for one self;

(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;

(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or

(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment…

(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:

(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;

(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;

(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:

1.Recent patterns of extensive or severe substance abuse;

2.Inability to establish a period of sobriety without continuous supervision and structure;

3.Presence of significant resistance or denial of an identified substance abuse problem; or

4.Limited recovery skills and/or support system; and

(D) A client may qualify for transfer from outpatient to residential treatment if the person:

1.Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or

2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment…

(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.

(A) Eligibility for primary treatment shall be based on:

1.Evidence that the person cannot achieve abstinence without close monitoring and structured support; and

2.Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1.Ability to limit substance use and remain abstinent without close monitoring and structured support;
2.Absence of crisis that cannot be resolved by community support services;
3.Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4.Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:
1.Lack of need for structured or intensive treatment;
2.Presence of adequate resources to support oneself in the community;
3.Absence of crisis that cannot be resolved by community support services;
4.Willingness to participate in the program, keep appointments, participate in self-help, etc.
5.Evidence of a desire to maintain a drug-free lifestyle;
6.Involvement in the community, such as family, church, employer, etc.; and
7.Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program…

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1.The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2.For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of ADA; and

3.An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1.The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2.At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D)The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit monitored agencies' level assignments to the initial level of care given information provided via the CIMOR system and clinical information supplied by providers during the utilization review process. Any concerns related to the referral of individuals to the most appropriate treatment modality could then be followed up on with the providers and appropriate ADA staff. The certification standards outlining the clinical utilization review process are as follows:

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are

necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A)The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B)Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C)Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1.Length of stay beyond any specified maximum time period;

2.Service authorization beyond any specified maximum amount or cost;

3.Admission of adolescents into adult programs; and

4.Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D)Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E)The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F)Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1.Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and

2.Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

Another important avenue to providing the most appropriate, individualized treatment modality to those seeking substance abuse treatment is access to specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The Division of ADA maintained contracts with CSTAR programs throughout the state to provide specialized services to populations including women and children, adolescents, and opioid-dependent consumers.

The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange for daycare and therapeutic services for children who accompany their mothers in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to consumers between the ages of twelve and seventeen inclusive, and their families. These programs focus on therapeutic issues relevant to adolescents

including recovery issues such as peer relationships; use of leisure time; abuse and neglect; skill development, such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate. The opioid CSTAR programs are designed to utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle.

FY 2010 Progress

Eligibility criteria are defined in certification standards. Assessment Severity Index (ASI) assessment results (for adult programs) or Global Assessment of Individual Needs (GAIN) assessment results (for adolescent programs), and eligibility criteria are to be used when determining the most appropriate treatment modality and level of care assignment for consumers.

While most providers of adult substance abuse services use the traditional version of the ASI, the Division of Alcohol and Drug Abuse (ADA) approved the use of the ASI-MV to contracted agencies in October 2008. The ASI-MV is an interactive self-administered computer-based assessment that has shown strong reliability and validity. Starting in October 2008, Inflexxion, the ASI-MV vendor, provided training and technical assistance to five agencies piloting the use of the ASI-MV. The Division offered periodic conference calls to provide a forum to field questions and provide additional assistance during this initial trial period. During the first year of implementation, ADA purchased the administrations directly from Inflexxion and dispersed to agencies on an as needed basis to encourage the use of the instrument. In FY 2010, ADA arranged for agencies to directly purchase the administrations from the vendor, Inflexxion, with the ability to be reimbursed an administration fee from ADA via the development of a billable service code. Approval was also received from MO HealthNet (Medicaid) to make this a covered service for eligible recipients. At least two agencies from phase one of the pilot project have expanded use of this tool to their satellite offices. Over the past year, the Division has continued to promote the ASI-MV as a useful and valid assessment to encourage additional agencies to implement its use. There has been one webinar provided for interested agencies to learn more about the ASI-MV and its applicability to their treatment programs.

The Division of Alcohol and Drug Abuse (ADA) maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children, adolescents, and opiate-dependent consumers. During FY 2010, there were twelve (12) women and children's CSTAR programs (includes two Alt Care programs specializing in treatment for women released from correctional institutions), fourteen (14) adolescent CSTAR programs, and four (4) opioid CSTAR agencies providing these specialized services in Missouri. The general population CSTAR programs and the community-based Primary Recovery Plus (PR+) programs continue to offer an array of community-based clinical substance abuse treatment services within multiple levels of care, based on the consumer's assessed needs. These services are delivered according to the genuine, free, and independent choice of provider, appropriate for the consumer's assessed needs.

The original award of Access to Recovery (ATR) funds allowed the enhancement of all existing primary recovery programs to provide the full array of services including relapse prevention, vocational support, and trauma services. In some cases, services were expanded into areas that are underserved. In other areas, nontraditional and faith-

based organizations have been credentialed to provide recovery support services in their communities. Specific recovery support services available from credentialed nontraditional and faith-based organizations through the ATR grant include: re-entry coordination, care coordination, childcare, drop-in center, emergency/temporary housing, family engagement, pastoral counseling, individual and group recovery support, spiritual life skills, and transportation. There were 103 recovery support providers credentialed and contracted to provide these services in FY 2010. The Missouri Institute of Mental Health (MIMH) serves as the contractor for technical assistance on consumer tracking and follow-up data collection for the ATR project.

Missouri has applied for the third round of Access to Recovery Grants. Missouri's previous ATR grants have been extremely successful in terms of increasing access to services, promoting consumer choice, and engaging faith- and community-based providers to offer an array of recovery support services that have resulted in positive consumer outcomes. The state believes it is now time to shift its strategy for the third grant to a more well-defined target population, along with greater emphasis on infrastructure development at the local level. The state will define two tracks within the primary recovery treatment program – an ATR-funded track and a non-ATR funded track. The ATR-funded track will have unique aspects that will differentiate it from the customary Primary Recovery Plus (PR+) treatment program track.

Missouri's application for a third Access to Recovery grant ("ATR III") will transform and enhance the ATR program by:

- focusing on the development of a recovery-oriented system of care that supports longer periods of consumer engagement;
- utilizing place-based strategies through solicitation of proposals from existing ATR providers that explain how they will strengthen the state's implementation of the ATR model at the local level;
- strengthening collaborative relationships with the Missouri National Guard, veterans' organizations, and the Missouri Department of Corrections; and,
- expanding the network of recovery support providers to more specifically address priority and disadvantaged populations.

In ATR III, the well-established clinical treatment and recovery support infrastructure will continue to serve a broad spectrum of individuals, but will prioritize the delivery of services and supports to the following critical populations:

1. Veterans and National Guard soldiers returning from the Iraq-Afghan war and their families;
2. Treatment court participants;
3. Department of Corrections offenders returning to the community.

While prioritizing the above populations, ATR III funds will also be used to provide clinical treatment and recovery support services for many adults in Missouri without Medicaid benefits.

In an effort to better meet the needs of consumers with co-occurring mental health disorders, enhance the quality of care, and promote provider utilization of evidence-based practices, additional services were added to the service menus of all contracted providers in FY 2008. These services include the following: Individual Co-Occurring Disorder Counseling, Medication Services (delivered by physician, advanced practice nurse, or psychiatrist), Extended Day Treatment (nursing service), Medications and the Clinical Supervision of Counselors. Utilization of these services has increased significantly since that time, particularly use of medication-assisted treatment.

The Clinical Utilization Review Unit continues to review authorization requests and assessments for compliance with certification standards, as well as, for appropriateness of placements in the continuum of care and specific clinical services made available to consumers. Significant exploration has been conducted on deriving meaningful utilization data from the Customer Information Management Outcomes and Reporting (CIMOR) system. Considerable data can be retrieved and ad hoc reports have been successfully developed (example: provider trends in level assignment). Some data must still be rendered by manual tracking.

The Division of ADA has made clear the expectations that contracted providers deliver highly individualized services to consumers, providing them what they need: no more, no less. This requires a comprehensive assessment and a thoughtful, well-developed treatment plan. It requires a person-centered approach and openness to using evidence-based treatment approaches and interventions. ADA places great emphasis on the importance of attending to the recovery domains of abstinence, stable housing, employment/education, social connectedness, reduced legal problems, and increased retention in treatment. The Division will continue to maintain high expectations for providers, assisting them in reducing barriers that may impede their progress in meeting these goals.

Goal #11: Continuing Education

An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. §300x-28(b) and 45 C.F.R. §96.132(b)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-13 Intended Use

Future Department of Mental Health Spring Training Institutes will be held May 20-21, 2011; May 31-June 1, 2012; and May 30-31, 2013. Workshops provided at the institutes provide continuing education units (CEUs) for prevention and treatment credentials.

In FY 2010, the Division of Alcohol and Drug Abuse (ADA) applied for the third round of Access to Recovery grants (ATR III). In its proposal, ADA plans to provide training to participating service providers in the areas of ethics and boundaries; stages of change; various pathways to recovery; cultural competency, including that of military culture; Government Performance and Results Act (GPRA); the ATR voucher management system and person-centered planning; and ATR documentation, policies, and procedures. Individuals performing recovery coordination will receive specialized training in motivational interviewing techniques to enhance consumer engagement. In addition, the ADA Office of Faith-Based and Community Partnerships (OFBCP) will work to identify additional training needs for recovery support and treatment providers to foster partnerships between the organizations.

The Statewide Training and Resource Center (STRC) will provide training and technical assistance to Regional Support Center staff and community leaders on behalf of the Division to support their capacity to respond to community level prevention efforts. The STRC, with assistance from our Southwest Regional Expert Team, will present statewide and regional workshops throughout the year. Training and technical assistance will focus on implementing the strategic prevention framework in addressing local and statewide substance abuse issues. The STRC will plan for the Missouri Statewide Prevention Conference to be held December 10, 2010. Future dates have not been identified. The annual Prevention Conferences will provide training on current issues and prevention needs impacting the substance abuse field. National and local experts will present on a range of topics including: using social marketing to create policy change, substance use, problem behaviors and suicidal ideation among Missouri's youth, prescription and over the counter medications, modifying model programs to meet local needs, the future of public support for prevention, gang awareness and prevention, media literacy in prevention, bullying, as well as other current issues impacting the substance abuse field.

The STRC will continue to offer training for Prevention Specialists to acquire or maintain Missouri Substance Abuse Prevention credentials under the Missouri Substance Abuse Professional Credentialing Board (MSAPCB) such as, ethics training, and train-the-trainer for Substance Abuse Prevention Specialists Training (SAPST). ADA will continue to identify web-based learning opportunities for prevention staff and providers to enhance their prevention skills.

The Southwest Regional Expert Team (SWRET) will continue to provide training and technical assistance to ADA to support ongoing implementation of the Strategic Prevention Framework as community coalitions continue to assess their data,

implement their evidence-based programs and work to sustain their programs. The SWRET will continue to provide technical assistance to ADA to support enhancement of the state's epidemiology workgroup.

ADA prevention staff will continue to provide technical assistance to the providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practice and science-based intervention services.

ADA plans to continue their partnership with the Department of Health and Senior Services (DHSS) to provide HIV pre- and post-test counseling training to substance abuse provider staff. The training curriculum will be directly provided by DHSS regional training staff and will meet the federal guidelines of the Centers for Disease Control and Prevention. To ensure continuity of this collaboration, DHSS and DMH will continue the Memo of Understanding (MOU) that outlines their respective responsibilities. DHSS and ADA will continue their representations at DHSS and ADA statewide meetings to guide and assist in the development of prevention and treatment activities and strategies as related to health, mental health, substance abuse and sexually transmitted disease and blood borne diseases. ADA will continue to disseminate statistical data collected by DHSS to ADA providers and to encourage continued networking with regional DHSS health centers and staff for education and training assistance, referrals for testing and treatment, and development of policies and procedures to address these related issues.

FY 2008 Compliance

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 14-16, 2008 with 1,300 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma informed care, criminal justice, ethics, faith-based recovery support, effective models for prevention in the treatment setting as well as other current issues impacting the substance abuse field.

The Missouri Access to Recovery II (ATR II) program, funded by a grant from the Substance Abuse and Mental Health Services Administration, was implemented during FY 2008. In fall 2007, regional trainings provided information on the ATR program to prospective service providers. Additional meetings were held in spring 2008 to foster agency networking and to provide education on ATR policies and procedures. The Division of ADA partnered with the Committed Caring Faith Communities (CCFC) to recruit, train, and credential faith-based and nontraditional recovery support providers. Key staff and volunteers were required to attend a 32 hour course offered by CCFC called "Addictions Academy". Academy classes cover the basics of addiction, prevention, co-dependency and family dynamics, how to approach the user, the difference between sin and addiction, spirituality as a critical component of recovery; how to set up a faith-based substance abuse program, twelve-step interpretation, how to become a certified substance abuse counselor, use of the CAGE-AID screening instrument, and co-occurring disorders. For participating ATR II providers, trainings were provided on the ATR model, including client choice; Government Performance and Results Act (GPRA) and GPRA follow-up tracking; ATR voucher management; and ATR documentation, policies, and procedures.

Regional Collaborative Model trainings provided subsequent cross-training opportunities for the Division of Alcohol and Drug Abuse (ADA) and the Department of Health and Senior Services (DHSS) contracted providers. Participating DHSS and ADA treatment staff were provided with updated regional epidemiological data and responsive risk reduction methods to address consumer health risk factors associated with HIV/AIDS, STDs, TB, and Hepatitis. Regional collaboration plans were revised and updated to reflect the current progression of this regional service delivery model. Through regional trainings, additional action steps were identified to increase collaboration, resource development, and regional responsiveness.

ADA worked collaboratively in partnership with DHSS to provide the HIV pre- and post-test counseling training to DMH contracted provider staff. The DHSS has made the commitment to ADA to make their HIV trainings open to all ADA provider staff at no cost to the providers. ADA provider staff has been encouraged to pursue this required training at the regional level with their DHSS and local Department of Health staff.

ADA provided training, education, and technical assistance through the Missouri Statewide Training and Resource Network (STRC). Training and technical assistance were provided to Regional Support Center staff and community leaders to promote

community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations.

The Southwest Center for the Application of Prevention Technology (SWCAPT) continued to provide technical assistance to ADA to support the implementation of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions respond to the requirements for data driven targeted prevention intervention strategies.

Beginning in 2008, ADA required contracted direct service prevention staff to obtain the first level prevention credential with the Missouri Substance Abuse Professional Credentialing Board (MSAPCB). ADA worked with the MSAPCB to develop criteria for the three levels of Prevention Specialists credentials for Missouri: Missouri Substance Abuse Prevention Associate (MSAPA), Certified Reciprocal Prevention Specialist (CRPS), and Missouri Advanced Certified Substance Abuse Prevention Professional (MACSAPP).

ADA regional prevention staff continued to provide technical assistance to providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practices and science-based intervention services.

FY 2010 Progress

The Department of Mental Health (DMH)'s annual Spring Training Institute scheduled for May 20-21, 2010 yielded 907 individuals with interest in the substance abuse prevention and treatment fields. National and local experts presented on a range of topics including ethics, medication assisted treatment, trauma, child welfare and substance abuse, faith-based recovery support and recovery oriented systems of care.

Collaboration with the Mid-America Addiction Technology Transfer Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention (CSAP) continues to ensure that employees of treatment and prevention agencies in Missouri receive training and education to promote the use of evidence-based practices.

The Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff continues to provide training to the clinical treatment and recovery support providers throughout the state. Technical assistance trainings include ensuring proper documentation and educating on invoicing techniques as well as providing information on appropriate business practices. Training on the Government Performance and Results Act (GPRA) and the ATR voucher management system are available to both clinical and recovery support providers upon request.

The Statewide Training and Resource Center (STRC) provides training and technical assistance to Regional Support Center staff and community leaders on behalf of the Division to support their capacity to respond to community level prevention efforts. Trainings are also offered to satisfy specific requirements of the Missouri Substance Abuse Professional Credentialing Board (MSAPCB) for Substance Abuse Prevention Specialists. The STRC, with assistance from our Southwest Regional Expert Team (SWRET) Liaison, have presented a number of statewide workshops throughout the year including: Strategic Prevention Framework, Prevention Across the Lifespan, Prevention Ethics, Substance Abuse Prevention Specialist Training (SAPST), SAPST train-the-trainer, and "The Odd Couple, When Prevention meets Treatment." The STRC also hosted the Partnership for Drug Free America (PDFA) trainings: Parents 360, Meth 360,,and WreckED For Youth. The STRC held Alliance for Justice Advocacy trainings for prevention and treatment professionals and providers. The Southwest Regional Expert Team (SWRET) also provides additional training and technical assistance to ADA to assist in enhancing our epidemiology workgroup.

ADA regional prevention staff continue to provide technical assistance to the providers of the School-based Prevention Intervention and Resources Initiative (SPIRIT) to encourage their utilization of best practice and science-based intervention services.

The Division of ADA continues its collaboration with the Department of Health and Senior Services (DHSS). DHSS provides HIV pre-and post-test counseling training to substance abuse providers in accordance with federal guidelines of the Centers for Disease Control and Prevention and at no cost to providers. In partnership with DHSS regional staff, technical assistance is provided to ADA staff and providers to reduce the

incidence of sexually transmitted and blood borne diseases among the substance abusing population. Representatives from both DHSS and ADA provide cross collaboration to assist staff, professionals and consumers in finding resources and referrals for education, testing, treatment and training. ADA and DHSS representation continues to be present and actively involved with the State Advisory Council – Community Planning Group with ADA and DHSS providing guidance and insight on interrelated issues of mental health, infectious diseases, and substance abuse.

Goal #12: Coordinate Services

An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. §300x-28(c) and 45 C.F.R. §96.132(c)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of polices for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 - FY 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education, early intervention, and family services will continue to be addressed in Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. Specialized programs will continue to provide treatment for adolescents, those addicted to opiates, pregnant women, and women with dependent children. These programs provide additional programming and also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of these populations.

ADA will continue to develop programs and to incorporate prevention and treatment programs as needed based upon consumer needs and priority populations. ADA will continue to monitor prevention and treatment programs to assure that providers have established and maintained linkages to community and state resources. SAC will continue to incorporate members from providers, community, consumers, and state agencies. SAC will continue to address prevention and treatment needs and to develop state plans to incorporate best practices. Spring Training Institute will continue to provide a low-cost opportunity for providers to learn about the work of other stakeholders and to network.

While Missouri's Access to Recovery II (ATR II) grant award is ending in September 2011, Missouri has applied for the third round of ATR grants. Missouri's previous ATR grants have been extremely successful in terms of increasing access to services, promoting consumer choice, and engaging faith- and community-based providers to offer an array of recovery support services that have resulted in positive consumer outcomes. The state believes it is now time to shift its strategy for the third grant to a more well-defined target population, along with greater emphasis on infrastructure development at the local level. The state will define two tracks within the primary recovery treatment program – an ATR-funded track and a non-ATR funded track. The ATR-funded track will have unique aspects that will differentiate it from the customary Primary Recovery Plus (PR+) treatment program track.

Missouri's application for a third Access to Recovery grant ("ATR III") will transform and enhance the ATR program by:

- focusing on the development of a recovery-oriented system of care that supports longer periods of consumer engagement;
- utilizing place-based strategies through solicitation of proposals from existing ATR providers that explain how they will strengthen the state's implementation of the ATR model at the local level;
- strengthening collaborative relationships with the Missouri National Guard, veterans' organizations, and the Missouri Department of Corrections; and,

- expanding the network of recovery support providers to more specifically address priority and disadvantaged populations.

The Office of Faith-Based and Community Partnerships was established in March 2007. This office will continue to coordinate the efforts of faith-based recovery support providers with those of the substance abuse treatment and prevention providers and ADA staff.

The Division of ADA and contracted providers will continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction, assessment, education, and treatment of active diseases. Continued regional collaborative trainings will be available to ADA providers to support the use of timely epidemiological data and to strengthen collaborative partnerships between ADA and DHSS providers.

The Division of ADA will continue to provide funding for program implementation and evaluation at the five School-based Prevention Intervention and Resources Initiative (SPIRIT) sites. Evaluators will continue to track the number of referrals made through the project. Performance measures will include the Teacher Observation Checklist, the California Healthy Kids Survey, the Missouri Student Survey, the SPIRIT Fidelity and Quality of Program Implementation Report, the Youth Satisfaction Survey, and the teacher responses obtained from the SPIRIT Initiative Questionnaire.

In collaboration with the Missouri Department of Elementary and Secondary Education, ADA will continue to support the Internet-based administration of the Missouri Student Survey in all Missouri school districts. The Missouri Student Survey will be administered in 2012. Local districts and ADA will continue to use survey results for planning and program development.

The State Epidemiological Workgroup (SEW) will be enhanced and continue to promote cooperation and coordination with other substance abuse data system gatekeepers and users to enhance data quality, specificity, and utilization. The SEOW will explore new avenues for conveying substance abuse epidemiology information to policy makers, planners, prevention project implementers, and other stakeholders. ADA also plans for the SEW to be very instrumental in the enhancement of a data querying site available to the public. Currently only Missouri Student Survey data is available through ADA's data querying site.

ADA will continue to partner with representatives of local, state, and national level agency work groups, task forces, and councils to coordinate substance abuse prevention efforts. These groups target specific issues and age groups including: the Missouri Coordinated School Health Coalition (MCSHC), Council for Adolescent School Health (CASH), the Suicide Prevention Advisory Council; Screening, Brief Intervention, Referral, and Therapy (SBIRT) workgroup; Mental Health Transformation workgroups, and the National Organization on Fetal Alcohol Syndrome (NOFAS)-Missouri.

ADA will continue support of the Missouri Youth/ Adult Alliance (MYAA) and the Missouri Recovery Network (MRN). MYAA is a statewide coalition to reduce underage drinking. MYAA's mission is to empower community advocates to reduce youth access to alcohol. The Missouri Recovery Network is a network of persons in personal recovery from substance abuse, their family members, and other supportive individuals. The main function of MRN is to develop a constituency who will advocate for the rights of substance-addicted individuals. The initiatives will continue to collaborate to include a Recovery Panel at the annual MYAA advocacy day events.

ADA will continue to recommend Community Based Organization (CBO) participation in Town Hall Meetings (THMs) to prevent underage drinking .supported by the Substance Abuse and Mental Health (SAMSHA).

FY 2008 Compliance

The advisory council network continued to be an important link between the public and the Division of Alcohol and Drug Abuse (ADA). The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), is established by state statute and is an advisory body to the Director of ADA. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services and no more than one-fourth can be ADA treatment or prevention contract providers. The SAC collaborates with ADA in developing a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol and other drug abuse. The SAC reviews current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public treatment programs and other specialized services. The SAC recommends specific methods, means, and procedures that should be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding.

The following certification standards address the coordination of treatment services. Certification standard 9 CSR 10-7.010, Treatment Principles and Outcomes, states the following:

(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.

2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.

3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.

4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.

5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

Workgroups established between the Office of State Courts Administrator (OSCA) and ADA developed policies and procedures for consumers involved in Missouri Drug

Courts. Similarly, the Department of Corrections and ADA work together to develop reentry programs to prevent relapse and recidivism. Community support workers are required to maintain an active directory of community and state resources, which are available to consumers who are involved in CSTAR substance abuse treatment programs. Further assurances of collaboration between ADA providers and community/state resources are monitored through certification visits and clinical reviews through CIMOR.

Adolescent Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standard 9 CSR 30-3.192 (3) (F) requires the following:

Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas.

Coordination of education for adolescent consumers during treatment is required by standards. All consumers in CSTAR programs are offered a community support worker whose responsibilities include "activities with or on behalf of a particular consumer in accordance with an individual rehabilitation plan to maximize the consumer's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting consumer independence and responsibility." The community support worker arranges, refers, and monitors services external to the CSTAR program. Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: build self esteem; learn to identify and express feelings; build positive family relationships; develop decision-making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe, drug-free environment.

All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well-being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on

probation and parole. The dependent children are provided child care and treatment for physical, emotional, and behavioral conditions brought about by their mothers' addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis (TB) in high-risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV, TB, STD, and hepatitis risk assessments for all consumers. High risk consumers were provided pre-test counseling, testing referral, and post-test counseling services. ADA designated staff continued to serve as liaisons with DHSS and ADA contracted treatment providers to respond to incidents or questions and to provide assistance with dissemination of infectious disease information.

ADA continued to work with the DHSS on the placement of Fetal Alcohol Syndrome (FAS) infant manikins. The manikins, placed in CSTAR sites and Regional Support Centers (RSCs) are an educational tool for FAS prevention. ADA continued to work collaboratively with the DHSS on the Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA continued training the five participating Women and Children's CSTAR programs as needed. The training included fundamentals of Motivational Interviewing and instructions for providing the Healthy Balance Intervention Strategy to eligible women receiving treatment in the five CSTAR programs. Additional educational FAS curriculum continued to be used by the participating CSTAR sites for consumer education.

ADA continued support for the Missouri School-based Prevention Intervention and Resources Initiative (SPIRIT) in the existing five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program is a collaborative between ADA, the school site, the contracted agency, and the evaluator. SPIRIT continued to provide evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in the SPIRIT initiative included Positive Action, Life Skills Training, Second Step, Too Good for Drugs, Project Towards No Drug Abuse, Peace Builders, and Reconnecting Youth. Outcome measurement included use of the Teacher Observation Checklist (K-3), the Fidelity and Quality of Program Implementation Report, a revised Healthy Kids Survey (grades 4-5), the SPIRIT Survey for (grades 6-12), and the Youth Satisfaction Survey.

ADA continued to partner with representatives of local, state, and national level agency work groups, task forces, and councils to coordinate substance abuse prevention efforts. These groups target specific issues and age groups including: the Missouri

Coordinated School Health Coalition (MCSHC), Council for Adolescent School Health (CASH), the Suicide Prevention Advisory Council; Screening, Brief Intervention, Referral, and Therapy (SBIRT) workgroup; Mental Health Transformation workgroups, and the National Organization on Fetal Alcohol Syndrome (NOFAS)-Missouri.

ADA continued to collaborate with Missouri Department of Elementary and Secondary Education (DESE) for the Internet-based administration of the 2008 Missouri Student Survey (MSS).

Under ADA direction, one statewide and forty-seven local coalitions hosted Town Hall Meetings (THMs) supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The 2008 THMs focused attention on the critical public health and safety issue and provided communities with the information and tools to answer *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking.*

FY 2010 Progress

During FY 2010, Missouri continued with second Access to Recovery (ATR II) grant, funded by the Substance Abuse and Mental Health Services Administration. Funding from this grant supports coordination and available alternatives among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional, and faith-based organizations; and, expands the existing managed care system. The ATR II grant fosters networking among clinical treatment providers and recovery support providers as well as other community resources offering services in support of sustained recovery.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by state statute and is an advisory body to the ADA Director. The SAC is comprised of 25 members appointed by the ADA Director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current trends and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends specific methods, means, and procedures to be adopted to improve and upgrade the service delivery system and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. During FY 2007, the SAC established Treatment and Prevention subcommittees to collaborate with appropriate ADA staff, provide feedback and provide suggestions into the planning and budget process for ADA activities. These subcommittees continue to meet regularly.

Comprehensive Substance Treatment and Rehabilitation (CSTAR) program certification standards continue to require ADA contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of consumers. ADA has provided numerous technical assistance visits and sponsored statewide meetings of providers to facilitate creative collaborative relationships with community resources. Continued assurances of existing collaboration between ADA providers and community/state resources are monitored through certification visits and clinical reviews through CIMOR. Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional, and behavioral conditions brought about by their mothers' addiction. ADA continues to collaborate with DOC on their Missouri Reentry Program which was

initiated with the Transition from Prison to Community Project. The primary objective of this program is to assist transitioning offenders with developing early and effective linkages to community treatment and mental health resources.

The Division of ADA and contracted providers continue to be actively involved in disease prevention activities in collaboration with the Department of Health and Senior Services (DHSS), which include screening, risk reduction assessment and education, and treatment of active diseases. DHSS maintains statistical data on trends of infectious diseases, and this data is disseminated to DMH prevention and treatment providers to assist providers in identifying high risk populations within geographical services areas. A collaborative agreement between DHSS and ADA continues to provide for the collection and transmission of data, cross training, and professional guidance on policy development, program development, and service referrals. A representative from DHSS sits on the SAC. DHSS seeks ADA guidance on mental health issues in the development of prevention and treatment programs for HIV/AIDS/STD community planning coalitions. Regional coalitions and health departments provide education, testing, treatment, and training to ADA providers and consumers.

ADA continues to work collaboratively with the DHSS on the placement of Fetal Alcohol Syndrome (FAS) infant manikins. The manikins, placed in CSTAR sites and Regional Support Centers (RSCs) are an educational tool for FAS prevention.

ADA has introduced the “Early Interventions” service. The ADA Early Intervention Services program is briefly described as providing evaluation, education, and early intervention services for individuals with problems or risk factors related to substance use, but for whom an immediate substance-related disorder cannot be confirmed or immediate admission to clinical treatment is not warranted. Situations include referrals from Probation and Parole, courts, schools, and other agencies when a written report of findings from a substance abuse professional is needed. The service delivery location is not limited to the clinical treatment agency. Other appropriate sites in which the service may be provided include school, home, local probation and parole office or other community locations, when warranted.

As a result of increased need, the Department of Mental has recognized the co-occurring issues that can be related specifically to veterans and has been working to address the specific needs of this population. ADA has a representative from the Missouri National Guard who sits on SAC and provides technical advice and recommendations on prevention and treatment programs.

ADA collaborates with the Division of Comprehensive Psychiatric Services on the Missouri Youth Suicide Prevention grant. This grant provides prevention and treatment resources to Missouri consumers who could be at risk for suicide. Evidence based trainings on risk factors, which include co-occurring disorders and substance abuse, are available to the agencies, community groups and individuals.

The Division of ADA continues the Missouri School-based Prevention Intervention and Resources Initiative (SPIRIT). The Missouri SPIRIT program provides evidence-based prevention programs to over 9,000 students in grades K–9. The curricula used are Life Skills Training, Peace Builders, Too Good For Drugs, Second Step, and Project Towards No Drug Abuse. Prevention providers assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT objectives are to delay onset of chemical use, decrease substance use, improve overall school performance, and reduce violence. The Missouri Institute of Mental Health has continued to provide program evaluation, collecting three types of data: individual, school or group, and program fidelity. The following measures continue to be used: Teacher Observation Checklist (K-3), SPIRIT Fidelity and Quality of Program Implementation Report, Healthy Kids Survey (grades 4-5), and the SPIRIT Survey (grades 6-9). Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age, and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

In FY 2010 Missouri's Strategic Prevention Framework State Incentive Grant (SPF SIG) consisted of 17 coalitions (16 local and one statewide). All 17 coalitions continue to implement evidence-based programs. SPF SIG staff continues to provide training and technical assistance to the SPF SIG recipients to help them with implementation, evaluation, and sustainability. Missouri's state priority under this grant is to reduce risky drinking for persons aged 12-25 years.

The State Epidemiological Outcome Workgroup (SEOW) continues to promote cooperation and coordination with other substance abuse data system gatekeepers and users to enhance data quality, specificity, and utilization. The SEOW focuses particular attention on Missouri data including the Behavioral Risk Factor Surveillance System (BRFSS), the Missouri Information for Community Assessment (MICA) system, Missouri pharmaceutical databases, and data submitted by the SPF SIG coalitions for inclusion in the Learning Community website. The SEOW plans to develop additional data products using national and state data from the National Survey on Drug Use and Health, the Youth Risk Behavior Survey, and the Behavioral Risk Factor Survey. The SEOW will explore new avenues for conveying substance abuse epidemiology information to policy makers, planners, prevention project implementers, and other stakeholders. ADA is receiving technical assistance from the Southwest Regional Expert Panel in assisting the state in enhancing the epidemiology workgroup.

ADA continues to partner with representatives of local, state, and national level agency work groups, task forces, and councils to coordinate substance abuse prevention efforts. These groups target specific issues and age groups including: the Missouri Coordinated School Health Coalition (MCSHC), Council for Adolescent School Health (CASH), the Suicide Prevention Advisory Council; Screening, Brief Intervention, Referral, and Therapy (SBIRT) workgroup; Mental Health Transformation workgroups, and the National Organization on Fetal Alcohol Syndrome (NOFAS)-Missouri.

ADA continues to collaborate with Missouri Department of Elementary and Secondary Education (DESE) for the administration and evaluation of the Internet-based 2010 Missouri Student Survey (MSS).

ADA continues to support the Missouri Youth/ Adult Alliance (MYAA) and the Missouri Recovery Network (MRN). MYAA is a statewide coalition to reduce underage drinking. MYAA's mission is to empower community advocates to reduce youth access to alcohol. The Missouri Recovery Network is a network of persons in personal recovery from substance abuse, their family members, and other supportive individuals. The main function of MRN is to develop a constituency who will advocate for the rights of substance-addicted individuals. In March 2010, the initiatives collaborated to include a Recovery Panel at the annual MYAA advocacy day event. Members of the Missouri Recovery Network volunteered to sit on the panel as treatment and recovery experts. Youth that attended the advocacy day were encouraged to ask the panel questions about treatment and recovery. There were 230 participants at the MYAA and MRN event.

ADA continues to augment Community Based Organization (CBO) participation in the Substance Abuse and Mental Health (SAMSHA) supported Town Hall Meetings (THMs) by recommending additional CBO participation. During 2010, six additional CBOs for a total of 48 hosted THMs to prevent underage drinking.

Goal #13: Assessment of Need

An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. §300x-29 and 45 C.F.R. §96.133).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 Intended Use

The state will use a combination of data sources to maintain and update its substance abuse treatment needs assessment. Included among these data sources are the National Survey on Drug Use and Health (NSDUH) state and sub-state estimates. This assessment will be used in policy development, budgeting, treatment planning, and reporting. The treatment needs data and the alcohol and drug abuse indicators will continue to be presented in charts and tables and summarized in narrative form in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm).

Missouri estimates from the NSDUH and the indicators from the *Status Report* will also be used for prevention needs assessment and services planning. The Division of ADA will supplement these data with estimates from the biennial Missouri Student Survey (MSS), the annual Missouri College Health Behavior Survey (MCHBS), the Youth Risk Behavior Survey (YRBS), and the Behavioral Risk Factor Survey (BRFS). Collectively, data from these sources will identify trends in alcohol and drug use rates across age groups.

In summer 2010, ADA requested technical assistance from the Center for Application of Prevention Technologies (CAPT) on the assessment and revitalization of the State's epidemiological workgroup. In addition, the State is in the process of responding to the Substance Abuse and Mental Health Service Administration's (SAMHSA) request for proposals for the State Epidemiological Outcomes Workgroups Program. This contract will provide funding to support a data analysis / epidemiologist to coordinate and provide data support for the state epidemiology workgroup. The Division of ADA intends for the workgroup to have more focus on the production and dissemination of work products in support of ADA's prevention planning efforts. ADA research and prevention management will be guiding this effort.

ADA and its network of contracted Regional Support Centers will assist approximately 160 community coalitions to conduct or update prevention needs assessments, consistent with the SPF model when feasible. Ideally, each assessment will establish a foundation for a community to identify and prioritize its problems and needs based on local data, identify or develop necessary resources, plan and implement appropriate strategies and programs, and evaluate results.

ADA will collect community-level National Outcome Measures data specific to its prevention projects. Among all of Missouri's substance abuse prevention programs, data collection and analysis will support data-driven needs assessment, planning, implementation, and evaluation.

FY 2008 Compliance

In the development of the State's needs assessments, a combination of data sources were used including

1) state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH) survey,
2) state and sub-state estimates from the Missouri Student Survey (MSS),
3) state estimates from the Behavioral Risk Factor Survey (BRFS),
4) state estimates from the Youth Risk Behavior Survey (YRBS), and
5) state estimates from the Missouri College Health Behavior Survey (MCHBS).

For the treatment needs assessment, the Division of Alcohol and Drug Abuse (ADA) used the estimated number of individuals with alcohol or illicit drug dependence or abuse from the NSDUH as a proxy measure for treatment need. The treatment needs estimates were used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates were also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm). During FY 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2005-2006 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates for several measures and indicators from the survey. These tables were included in the ADA status report.

ADA collected an array of substance abuse indicator data, mostly from other state agencies. The indicators included a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collected other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the ADA planning regions, service areas, and the state. This data is published in the ADA Annual Status Report. Also included in the status report is narrative discussion of the highlights and trends of the data, the economic costs of substance abuse, and the challenges in addressing substance abuse issues.

The biennial MSS survey occurred in 2008. This survey represents a collaborative effort between the Department of Elementary and Secondary Education (DESE) and ADA. The survey instrument collects data on substance abuse incidence and prevalence, delinquent behavior, and risk and protective factors related to a range of health and safety issues. A report summarizing the results of this survey was published to the ADA public website: http://dmh.mo.gov/ada/rpts/MSS2008FinalReport.pdf.

In FY 2007, Missouri had its Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan approved by the Center for Substance Abuse Prevention (CSAP). In FY 2008, All 20 coalitions funded through SPF SIG were in the implementation phase of their projects. The coalitions worked on their strategic plans in which they assessed needs, resources, and readiness at the community level as part of their planning process. During FY 2008, SPF SIG staff continued to provide training and technical assistance to the SPF SIG recipients to help them with implementation, strategic planning and evaluation. Missouri's priority under this grant is to reduce risky drinking for persons aged 12-25 years.

FY 2010 Progress

In the development of the State's needs assessments, a combination of data sources are used including

1) state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH) survey,
2) state and sub-state estimates from the Missouri Student Survey (MSS),
3) state estimates from the Behavioral Risk Factor Survey (BRFS),
4) state estimates from the Youth Risk Behavior Survey (YRBS), and
5) state estimates from the Missouri College Health Behavior Survey (MCHBS).

For the treatment needs assessment, the Division of Alcohol and Drug Abuse (ADA) uses the estimated number of individuals with alcohol or illicit drug dependence or abuse from the NSDUH as a proxy measure for treatment need. The treatment needs estimates are used to estimate treatment penetration rates, plan and allocate treatment services, and develop the ADA portion of the Department of Mental Health's annual budget request. The estimates are also summarized in the annual *Status Report on Missouri's Alcohol and Drug Abuse Problems* (http://www.dmh.missouri.gov/ada/rpts/status.htm). During FY 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2007-2008 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates for several measures and indicators from the survey. These tables were included in the ADA status report. During FY 2010, ADA submitted a request to the SAMHSA Office of Applied Studies for additional analysis of the NSDUH data for Missouri. ADA continues to seek improvements and/or establishment of additional benchmarks in its treatment needs estimations.

ADA collects an array of substance abuse indicator data, mostly from other state agencies. The indicators included a variety of alcohol and drug related events including traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements, methamphetamine lab confiscations; probation, parole, and prison admissions; and drug court enrollments. In addition, ADA also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment. ADA annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, the ADA planning regions, service areas, and the state. This data is published in the ADA Annual Status Report. Also included in the status report is narrative discussion of the highlights and trends of the data, the economic costs of substance abuse, and the challenges in addressing substance abuse issues.

In spring 2010, the MSS survey was administered to over 100,000 secondary school students. This survey provides Missouri's largest set of data on alcohol and drug use, other behaviors, and risk factors among this population. During FY 2010, ADA contracted with the Missouri Institute of Mental Health to develop a web-based querying

tool for querying the 2008 MSS data. The site allows for the querying of factors based on educational environment, peer pressure, drug/alcohol usage, and community based perceptions. Aggregate data are available statewide and at the county level. The online querying tool went into production at the end of 2009. The tool is available for public use, including use by local coalitions in support of their needs assessment efforts: http://mostudentsurvey.mimh.edu/Default.aspx.

Missouri is nearly the end of its Strategic Prevention Framework State Incentive Grant (SPF SIG). In spring 2009, an updated epidemiological profile on alcohol use in Missouri was completed. The focus of Missouri's SPF SIG grant was to reduce risky drinking behavior, particularly, among youth and young adults. During 2010, SPF SIG staff worked with the University of Missouri to obtain BRFS data on alcohol use by zip code clusters. This data is being used as part of the evaluation phase of the grant.

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Goal #14: Hypodermic Needle Program

An agreement to ensure that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. §300x-31(a)(1)(F) and 45 C.F.R. §96.135(a)(6)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. This is specifically prohibited in provider contracts. Billing for such is not and will not be possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence will be ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which includes billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2008 Compliance

The Division of Alcohol and Drug Abuse (ADA) continued the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. Billing for such was not and is not possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers.

Policy adherence has been ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which includes billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

FY 2010 Progress

The Division of Alcohol and Drug Abuse (ADA) continues the policy that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. This was formalized through the addition of the following contract language:

> The contractor understands and agrees that payments received under the contract shall not be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection.

Billing for such is not possible in the Customer Information Management, Outcomes, and Reporting (CIMOR) system used by all contracted providers. Policy adherence continues to be ensured through various monitoring mechanisms: three-year certification surveys; Annual Safety and Basic Assurance Reviews, which include billing reviews; and, periodic site visits by the District Administrators and Area Treatment Coordinators.

Goal #15: Independent Peer Review

An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. §300x-53(a) and 45 C.F.R. §96.136).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness, and efficacy of the substance abuse treatment being provided in the state. Peer reviews continue to be required in contracts. Such reviews will be scheduled annually in each region of the state. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting process is in place to ensure information collected through the review process will be appropriately shared. Copies of the report will continue to be distributed to the District Administrator, the agency reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will continue to review the report with the appropriate agency staff if follow-up is necessary.

The National Treatment Network (NTN), a subgroup of the National Association of State Alcohol and Substance Abuse Directors (NASADAD), plans to have a focused topic call on Peer Review this fiscal year. Missouri's NTN will participate in the call to learn about other states' practices that might be beneficial to implement in Missouri to improve this process.

FY 2008 Compliance

The Division of Alcohol and Drug Abuse (ADA) utilized independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment and services provided. Seven (7) independent peer reviews were conducted in FY 2008. Contracts for treatment providers required that they make staff available to perform peer reviews of other agencies in the state.

The following is the language in contracts addressing peer review requirements:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and,

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2010 Progress

The Division of Alcohol and Drug Abuse (ADA) facilitated eight (8) peer reviews in FY 2010. Reviews are conducted in each region of the state and generally involve providers from different regions. Peer reviews are required of all providers contracting with the Division of ADA. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting process is in place to ensure information collected through the review process is appropriately shared. Copies of the report are distributed to the respective District Administrator, the agency being reviewed, and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator may review the report with the appropriate agency staff if follow-up is necessary.

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

Examples of **procedures** may include, but not be limited to:

• the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year ;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

FY 2009 Independent Peer Review

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness, and efficacy of substance abuse treatment services provided in the state of Missouri. ADA has been contractually requiring all treatment providers to participate in independent peer review since July 1993. Contracted providers have been cooperating with this requirement each year since that time. Seven (7) reviews were conducted in FY 2008, seven (7) were conducted in FY 2009, and eight (8) were conducted in FY 2010.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the respective ADA District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators, who work as Division of ADA regional staff and who report to the ADA District Administrators, are responsible for initiating the peer review process. A provider in the same region as the agency to be reviewed is contacted and asked to participate in this process. Peer reviewers are usually senior staff members of the contracted agency. Provider staff conducting the peer reviews are offered guidance from the ADA Area Treatment Coordinator. Expectations are relayed, optional tools for data collection are provided, and possible focus areas are suggested. Focus area suggestions may be based on prior survey

findings or areas of concern identified in other site visits, or if it is known that the peer reviewing agency has particular strengths in any given area of review.

A reporting process is in place to ensure information collected through the review process is appropriately shared. Copies of the report are distributed to the respective District Administrator, the agency being reviewed and ADA's treatment and fiscal staff. The ADA District Administrator and ADA Area Treatment Coordinator review the report with the appropriate agency staff if follow-up is necessary.

The agency being reviewed cooperates by providing access to consumer records, staff, and policy and procedure documents. The reviewer utilizes this information to establish the agency's compliance with certification standards, best practices, and efficiency in operations. Both the reviewer and the agency being reviewed have an opportunity to learn from one another, to the benefit of both programs. The information is also useful to ADA's certification specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the ADA Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal confidentiality regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

In summary, the role of ADA in Peer Reviews is as follows:

1. Providers are contractually bound to participate in Peer Reviews by ADA contracts;
2. The ADA Area Treatment Coordinators initiate the Peer Review;
3. The ADA Area Treatment Coordinators assure that the peer reviewer is a knowledgeable and experienced Substance Abuse Treatment Professional;
4. The ADA Area Treatment Coordinators assure the findings and recommendations of the Peer Review visit are reported in a timely fashion;
5. The ADA Area Treatment Coordinators review the findings and recommendations report;
6. The respective ADA District Administrator reviews the findings and recommendations of the Peer Review report;
7. The ADA District Administrator and Area Treatment Coordinator may review the report with the appropriate staff from the agency being reviewed, and provide technical assistance, if necessary.
8. The ADA District Administrator reviews significant deviations from contractual requirements or certification standards with the Executive Director of the reviewed agency;
9. The ADA District Administrator may review recurring problems with the ADA Division Director and other ADA administrative personnel;

10. The ADA District Administrator and Area Treatment Coordinator share positive findings of innovative practices in technical assistance visits to all providers to help disseminate improvements in clinical practice;
11. Copies of Peer Review findings and recommendations are filed in the agency's certification file.

The National Treatment Network (NTN), a subgroup of the National Association of State Alcohol and Substance Abuse Directors (NASADAD), plans to have a focused topic call on Peer Review in FY 2011. Missouri's NTN will participate in the call to learn about other states' practices that might be beneficial to implement in Missouri to improve this process.

Goal #16: Disclosure of Patient Records

An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. §300x-53(b), 45 C.F.R. §96.132(e), and 42 C.F.R. Part 2).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All Department of Mental Health employees will continue to be required to adhere to HIPAA policies. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with confidentiality regulations through certification surveys, Safety and Basic Assurances Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2008 Compliance

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage, and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitored the compliance of providers with the above confidentiality regulations through certification surveys, Safety and Basic Assurances Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

FY 2010 Progress

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage, and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. The language in contracts is quite comprehensive. All new ADA employees receive orientation and training to division policy and the above sited confidentiality laws. In April 2009, all Department of Mental Health (DMH) staff were reminded, by official memo, of the parameters and requirements related to the Notice of Privacy Practices for consumers of DMH-delivered services. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. ADA continues to monitor the compliance of providers with confidentiality regulations through certification surveys, Safety and Basic Assurance Reviews (SBAR) and periodic site visits by District Administrators and Area Treatment Coordinators.

Goal #17: Charitable Choice

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

Note: In addressing this narrative *please specify if this provision was not applicable because State did not fund religious providers. If* the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: *Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011 – FY 2013 Intended Use

The Missouri Code of State Regulations maintains the requirement that individuals not be denied admission or services based on creed. The right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

Religious organizations that provide Block Grant treatment services via contract with ADA will continue to be required to comply with Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract language for all providers includes the following as it relates to charitable choice:

Charitable Choice Notification

2.10.1 In the event the contractor is a religious organization, the contractor shall:

a. comply with the requirements of 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (see 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations;

b. provide consumers and prospective consumers with the “Notice to Individuals Receiving Substance Abuse Services”, attached hereto as Attachment I;

c. refer consumers to alternative services as requested if the consumer objects to the religious character or religious requirements of the organization and when alternative services are available;

d. maintain a log of requests for referral to alternative services based upon religious objection to which shall include the request date, consumer ID, disposition, and brief explanation; and

e. submit an annual report to the District Administrator, on or before July 31 of each year, containing the information required in subparagraph 2.10.1.d, above, for the prior fiscal year.

2.10.2 In the event the contractor utilizes subcontractors that are religious organizations, the contractor shall ensure that the Charitable Choice requirements stated in paragraph

2.10.1, above, are met by any subcontractors providing substance abuse treatment and prevention services.

2.10.3 If the contractor is a religious organization, the contractor shall declare as such, at the time of award, by way of written notification to the appropriate District Administrator.

a. If any subcontractor is a religious organization, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator at the time of award.

b. For any subsequent subcontracts established with religious organizations, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator prior to the subcontractor providing services.

Continuing training, certification and monitoring will ensure the consumers have charitable choice and quality services.

If Missouri is awarded another Access to Recovery grant, all recovery support services will continue to be authorized through a vouchering system as the result of the consumer's free and independent choice to receive such services from a recovery support provider within a network of credentialed providers. ATR-related trainings will continue to emphasize the core component of consumer choice in the program.

FY 2008 Compliance

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide Block Grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Guidelines, training, and technical assistance have been made accessible to providers.

All recovery support services were authorized through a vouchering system as the result of the consumer's free and independent choice to receive such services from a recovery support provider selected by the consumer from a menu of credentialed providers.

FY 2010 Progress

The Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances).

Faith-based organizations that provide Block Grant treatment services via contract with ADA are required to comply with Block Grant Charitable Choice requirements by following the procedures listed below

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract language for all providers includes the following as it relates to charitable choice:

Charitable Choice Notification

2.10.1 In the event the contractor is a religious organization, the contractor shall:

a. comply with the requirements of 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (see 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations;

b. provide consumers and prospective consumers with the “Notice to Individuals Receiving Substance Abuse Services”, attached hereto as Attachment I;

c. refer consumers to alternative services as requested if the consumer objects to the religious character or religious requirements of the organization and when alternative services are available;

d. maintain a log of requests for referral to alternative services based upon religious objection to which shall include the request date, consumer ID, disposition, and brief explanation; and

e. submit an annual report to the District Administrator, on or before July 31 of each year, containing the information required in subparagraph 2.10.1.d, above, for the prior fiscal year.

2.10.2 In the event the contractor utilizes subcontractors that are religious organizations, the contractor shall ensure that the Charitable Choice requirements stated in paragraph

2.10.1, above, are met by any subcontractors providing substance abuse treatment and prevention services.

2.10.3 If the contractor is a religious organization, the contractor shall declare as such, at the time of award, by way of written notification to the appropriate District Administrator.

a. If any subcontractor is a religious organization, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator at the time of award.

b. For any subsequent subcontracts established with religious organizations, the contractor shall require a written declaration from the subcontractor and shall submit the declaration to the District Administrator prior to the subcontractor providing services.

Two religious-based programs are currently certified by ADA to provide clinical substance abuse treatment. Consumers are informed of their right to Charitable Choice and are provided written acknowledgement of their alternatives. Guidelines, training, and technical assistance have been made available to providers.

Faith-based and nontraditional service organizations desiring to provide recovery support services must be credentialed by Committed Caring Faith Communities, an independent statewide not-for-profit 501(c) (3) interfaith corporation. There are 103 credentialed and contracted recovery support providers in Missouri of which 87 report being faith-based programs. In Missouri, all recovery support services are vouchered with the consumer making the genuine and independent choice of service provider from a network of credentialed recovery support providers.

Charitable Choice (formerly Attachment I)

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2010) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- ☑ Used model notice provided in final regulations
- ☐ Used notice developed by State (Please attach a copy in Appendix A)
- ☑ State has disseminated notice to religious organizations that are providers
- ☑ State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- ☐ State has developed specific referral system for this requirement
- ☑ State has incorporated this requirement into existing referral system(s)
- ☑ SAMHSA's Treatment Facility Locator is used to help identify providers
- ☑ Other networks and information systems are used to help identify providers
- ☑ State maintains record of referrals made by religious organizations that are providers
- ☑ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Charitable choice requirements are included in all provider contracts. The Access to

Recovery grants support a voucher-based program, of which consumer choice is fundamental. Each consumer served can choose between at least two service providers, to which at one they have no religious objection. That basic premise is repeated in all ATR policies and in trainings. This includes GPRA trainings and regional ATR meetings held every quarter. A total of 24 ATR-related trainings were held in FY 2010, all of which reinforced consumer choice as a core aspect of ATR. Additionally, a free-choice statement is printed on every ATR voucher.

Waivers (formerly Attachment J)

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Missouri does not plan to apply for any of the waivers.

Waivers

Waivers

If the State proposes to request a waiver at this time for one or more of the provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. §96.124(d), §96.128(d), §96.132(d), §96.134(b), and §96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

Waivers

Missouri is not requesting any waivers.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

	Source of Funds					
Activity	**A.SAPT Block Grant FY 2008 Award (Spent)**	**B.Medicaid (Federal, State and Local)**	**C.Other Federal Funds (e.g., Medicare, other public welfare)**	**D.State Funds**	**E.Local Funds (excluding local Medicaid)**	**F.Other**
Substance Abuse Prevention* and Treatment	$ 18,643,294	$ 28,125,237	$ 5,616,022	$ 36,217,878	$	$ 70,296
Primary Prevention	$ 6,113,644		$ 4,507,331	$ 910,853	$	$
Tuberculosis Services	$ 9,356	$ 20,780	$ 1,254	$ 9,475	$	$
HIV Early Intervention Services	$	$	$	$	$	$
Administration: Excluding Program/Provider	$ 1,301,926		$ 1,949,772	$ 1,592,089	$	$ 17,429
Column Total	**$26,068,220**	**$28,146,017**	**$12,074,379**	**$38,730,295**	**$0**	**$87,725**

***Prevention other than Primary Prevention**

Missouri is not an HIV designated state.

"Other" source of funds include Robert Wood Johnson Foundation Advancing Recovery Grant.

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	$ 760,228	$ 168,549	$ 125,879	$ 0	$ 0
Education	$ 2,980,274	$ 642,428	$ 47,272	$ 0	$ 0
Alternatives	$ 255,287	$ 0	$ 3,724	$ 0	$ 0
Problem Identification & Referral	$ 29,900	$ 0	$ 952	$ 0	$ 0
Community Based Process	$ 872,136	$ 200,000	$ 304,325	$ 0	$ 0
Environmental	$ 401,067	$ 81,678	$ 36,864	$ 0	$ 0
Other	$ 371,300	$ 3,414,675	$ 87,835	$ 0	$ 0
Section 1926 - Tobacco	$ 443,452	$ 0	$ 304,002	$ 0	$ 0
Column Total	**$6,113,644**	**$4,507,330**	**$910,853**	**$0**	**$0**

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	$ 1,282,545	$ 857,091	$ 193,689	$ 0	$ 0
Universal Indirect	$ 2,621,419	$ 1,015,444	$ 600,438	$ 0	$ 0
Selective	$ 2,209,680	$ 2,634,795	$ 116,726	$ 0	$ 0
Indicated	$ 0	$ 0	$ 0	$ 0	$ 0
Column Total	**$6,113,644**	**$4,507,330**	**$910,853**	**$0**	**$0**

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 SAPT Block Grant?
(•) Yes ( ) No

Expenditures on Resource Development Activities are:
(•) Actual ( ) Estimated

Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	$ 0	$ 286,223	$ 0	$ 286,223
Quality Assurance	$ 0	$ 0	$ 0	$ 0
Training (post-employment)	$ 0	$ 0	$ 0	$ 0
Education (pre-employment)	$ 0	$ 0	$ 0	$ 0
Program Development	$ 14,202	$ 623,105	$ 0	$ 637,307
Research and Evaluation	$ 0	$ 349,165	$ 0	$ 349,165
Information Systems	$ 0	$ 0	$ 0	$ 0
Column Total	**$14,202**	**$1,258,493**	**$0**	**$1,272,695**

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
1. Entity Number	2. I-SATS ID [X] if no I-SATS ID	3. Area Served	4. State Funds (Spent during State expenditure period)	5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services(other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
002	X	Northwest Region	$0	$2,129	$0	$0	$0
008	X	Central Region	$553,244	$104,808	$0	$650,498	$0
009	MO901642	Eastern Region	$524,257	$0	$0	$0	$0
021	MO102084	Northwest Region	$411,046	$4,152	$0	$0	$0
037	MO750593	Southwest Region	$642,538	$373,987	$0	$0	$0
052	X	Southwest Region	$525	$33,562			
062	MO101445	Central Region	$13,256				
082	MO101487	Eastern Region	$13,133				
090	MO100283	Eastern Region	$26,852				
152	X	Eastern Region	$78,789	$0	$0	$559,089	$0
154	X	Northwest Region	$8,830	$0	$0	$0	$0
156	MO100264	Southwest Region	$1,127	$3,819	$3,819		
171	X	Northwest Region	$119,126	$0	$0	$239,533	$0
173	MO903788	Eastern	$639,069	$391,679	$180,855	$0	$0

173	MO903788	Region					
174	MO103967	Eastern Region	$0	$0	$0	$0	$0
175	MO903515	Southwest Region	$0	$0	$0	$0	$0
183	MO100716	Northwest Region	$0	$578,822	$0	$0	$0
185	MO105152	Northwest Region	$23,825	$0	$0	$82,615	$0
189	MO100591	Eastern Region	$779,268	$249,296	$160,930	$0	$0
201	MO101433	Eastern Region	$265,531				
207	MO101031	Southwest Region	$46,257	$3,435	$0	$0	$0
208	X	Eastern Region	$56,267	$0	$0	$0	$0
209	X	Southwest Region	$75,832	$0	$0	$0	$0
210	X	Eastern Region	$118,723	$0	$0	$0	$0
211	X	Central Region	$0	$0	$0	$0	$0
216	X	Northwest Region	$16,655	$0	$0	$0	$0
217	X	Northwest Region	$91,229	$0	$0	$0	$0
220	X	Central Region	$1,644	$0	$0	$0	$0
226	MO101755	Northwest Region	$135,545	$10,970	$0	$0	$0
227	X	Eastern Region	$51,799	$0	$0	$0	$0
231	X	Central Region	$115,394	$0	$0	$0	$0
238	MO102027	Eastern Region	$50,578	$3,332	$0	$0	$0
239	MO101987	Eastern Region	$41,276	$5,098	$0	$0	$0
249	X	Eastern Region	$178,550	$0	$0	$0	$0
250	MO100727	Northwest Region	$856				
252	X	Southeast Region	$105,067	$0	$0	$0	$0
262	MO102928	Eastern	$1,249,675	$74,025	$0	$0	$0

262	MO102928	Region					
264	X	Southwest Region	$39,746	$0	$0	$0	$0
267	X	Statewide (optional)	$0	$232,958	$0	$850,073	$0
269	MO105087	Eastern Region	$0	$502,715	$0	$0	$0
274	X	Southwest Region	$66,677	$0	$0	$0	$0
275	MO100711	Central Region	$0	$0	$0	$0	$0
276	MO100849	Southwest Region	$365,298	$288,834	$0	$0	$0
277	X	Southeast Region	$19,018	$0	$0	$0	$0
282	X	Northwest Region	$33,973	$0	$0	$0	$0
287	X	Northwest Region	$19,848	$0	$0	$0	$0
288	X	Central Region	$25,329	$0	$0	$0	$0
297	X	Northwest Region	$0	$0	$0	$0	$0
312	MO101560	Southwest Region	$64,494	$147,795	$160		
315	X	Eastern Region	$34,215				
316	X	Eastern Region	$0	$0	$0	$0	$0
318	MO100761	Eastern Region	$0	$571,822	$0	$0	$0
401	X	Statewide (optional)	$0	$8,889	$0	$0	$0
402	X	Statewide (optional)	$0	$5,313	$0	$0	$0
403	X	Statewide (optional)	$0	$19,940	$0	$0	$0
405	X	Statewide (optional)	$18,000	$24,823	$0	$635,388	$0
406	X	Eastern Region	$0	$0	$0	$31,590	$0
408	X	Southwest Region	$0	$0	$0	$246,067	$0
411	X	Eastern Region	$0	$0	$0	$72,504	$0
412	X	Eastern	$0	$0	$0	$130,963	$0

412	X	Region					
413	X	Statewide (optional)	$0	$0	$0	$157,950	$0
414	X	Southeast Region	$0	$0	$0	$144,121	$0
416	X	Statewide (optional)	$0	$0	$0	$329,415	$0
417	X	Southeast Region	$25,955	$0	$0	$88,640	$0
418	X	Southeast Region	$37,253	$0	$0	$53,045	$0
420	X	Southwest Region	$116,401	$0	$0	$274,394	$0
421	X	Statewide (optional)	$0	$0	$0	$19,965	$0
423	X	Statewide (optional)	$89,775	$0	$0	$0	$0
428	X	Central Region	$89,857				
430	X	Southwest Region	$17,846	$0	$0	$0	$0
431	X	Statewide (optional)	$53,074	$0	$0	$0	$0
432	X	Statewide (optional)	$2,056				
433	X	Northwest Region	$48,498				
638	MO100667	Northwest Region	$141,480	$583,289	$0	$0	$0
043a	MO902004	Southwest Region	$141,229	$168,603	$0	$170,033	$0
043b	MO101030	Southwest Region	$0	$0	$0	$0	$0
043c	MO101267	Southwest Region	$0	$0	$0	$0	$0
045a	MO105244	Northwest Region	$768,746	$234,968	$0	$0	$0
045c	MO902608	Northwest Region	$48,318	$9,756	$0	$0	$0
045d	MO902673	Northwest Region	$71,515	$9,956	$0	$0	$0
045e	MO101047	Northwest Region	$1,397	$3,830	$0	$0	$0
045f	MO101048	Northwest Region	$5,052	$2,353	$0	$0	$0
045g	MO101532	Northwest	$121,915	$94,474	$0	$0	$0

049g	MO101332	Region					
048a	MO101028	Southwest Region	$31,979	$17,566	$0	$0	$0
049a	MO106614	Southwest Region	$12,891				
049aa	MO106317	Central Region	$572				
049b	MO106218	Southeast Region	$126,235	$42,682	$0	$4,524	$0
049c	MO103801	Southwest Region	$41,601	$23,649	$0	$2,507	$0
049d	MO106259	Southwest Region	$0	$0	$0	$0	$0
049e	MO901527	Southwest Region	$890,566	$431,674	$0	$45,753	$0
049g	MO106309	Southwest Region	$62,471	$7,492	$0	$794	$0
049h	MO103272	Northwest Region	$1,451	$1,509	$0	$160	$0
049i	MO106242	Southwest Region	$33,458	$19,648	$0	$2,083	$0
049j	MO100404	Southeast Region	$47,317	$6,930	$0	$735	$0
049k	MO103207	Central Region	$135,827	$11,703	$0	$1,241	$0
049l	MO105814	Central Region	$7,647	$737	$0	$78	$0
049m	MO103298	Central Region	$0	$0	$0	$0	$0
049n	MO105798	Central Region	$89,803	$9,562	$0	$1,013	$0
049o	MO103124	Northwest Region	$22,561	$10,380	$0	$1,100	$0
049p	MO103280	Northwest Region	$91,220	$112,511	$0	$11,925	$0
049q	MO901543	Northwest Region	$330,051	$205,428	$0	$21,774	$0
049r	MO103231	Northwest Region	$33,315	$19,228	$0	$2,038	$0
049s	MO103215	Northwest Region	$119	$0	$0	$0	$0
049t	MO100321	Central Region	$26,448	$3,027	$0	$321	$0
049v	MO106283	Central Region	$4,147				
049w	MO103918	Southwest	$34,887	$12,580	$0	$1,334	$0

049w	MO103918	Region					
049x	MO100865	Northwest Region	$20,584	$11,247	$0	$1,192	$0
049z	MO100808	Northwest Region	$30,590	$14,309	$0	$1,517	$0
052a	MO103389	Southwest Region	$1,268	$3,554	$0	$0	$0
052d	MO901501	Southwest Region	$566,956	$424,574	$0	$0	$0
052f	MO100650	Southwest Region	$88,815	$23,964	$0	$0	$0
052g	MO100787	Southwest Region	$120,738	$53,026	$0	$0	$0
052h	MO100304	Southwest Region	$0	$0	$0	$0	$0
053a	MO102159	Central Region	$562,003	$402,595	$0	$0	$0
055a	MO903911	Southeast Region	$926,425	$266,246	$0	$0	$0
055aa	MO100774	Southeast Region	$29,698	$10,959	$0	$0	$0
055ab	MO101135	Southeast Region	$66,654				
055b	MO103785	Southeast Region	$64,041	$24,733	$0	$0	$0
055c	MO104593	Southeast Region	$211,830	$42,499	$0	$0	$0
055e	MO100850	Southeast Region	$31,155				
055f	MO100848	Southeast Region	$31,364	$0	$0	$0	$0
055g	MO104791	Southeast Region	$56,931				
055h	MO100859	Southeast Region	$97,546	$12,650	$0	$0	$0
055j	MO100860	Southeast Region	$15,871	$3,413	$0	$0	$0
055l	MO100929	Southeast Region	$15,188	$234			
055o	MO100770	Southeast Region	$146,900	$26,610	$0	$0	$0
055p	MO100858	Eastern Region	$35,108				
055q	MO100853	Southeast Region	$31,388	$21			
055s	MO100847	Central	$32,851				

055s	MO100847	Region					
055u	MO105913	Southeast Region	$60,911	$19,521	$0	$0	$0
055w	MO100772	Southeast Region	$126,783	$31,893	$0	$0	$0
055x	MO100852	Southeast Region	$42,221				
055y	MO100855	Southeast Region	$68,383				
055z	MO100854	Southeast Region	$49,827				
056a	MO101128	Southeast Region	$534,112	$206,639	$200,982	$29,964	$0
056ac	MO101227	Southeast Region	$168,567	$125,391	$21,852	$18,183	$0
056b	MO301793	Southeast Region	$454,050	$306,589	$50,122	$44,458	$0
056c	MO101391	Southeast Region	$11,810	$0	$0	$0	$0
056e	MO100620	Southeast Region	$12,864	$7,633	$1,020	$1,107	$0
056f	MO000041	Southeast Region	$135,105	$101,859	$0	$14,770	$0
056g	MO903598	Southeast Region	$37,641	$138,327	$0	$20,058	$0
056h	MO105640	Southeast Region	$0	$0	$0	$0	$0
056i	MO100649	Southeast Region	$977	$1,701	$1,701	$247	$0
056j	MO100828	Southeast Region	$3,449	$1,429	$0	$207	$0
056k	MO101311	Southeast Region	$10,632	$5,772	$0	$837	$0
056l	MO105657	Southeast Region	$50	$20	$0	$3	$0
056m	MO105848	Southeast Region	$39,984	$17,015	$0	$2,468	$0
056n	MO750502	Southeast Region	$549,009	$249,722	$0	$36,212	$0
057a	MO100872	Northwest Region	$0	$0	$0	$0	$0
057b	MO106010	Northwest Region	$0	$0	$0	$0	$0
057d	MO100864	Northwest Region	$42,584	$38,113	$0	$0	$0
057e	MO101207	Northwest	$1,426,609	$221,576	$239,465	$0	$0

057e	MO101207	Region					
057f	MO104262	Northwest Region	$82	$0	$0	$0	$0
058a	MO100518	Northwest Region	$252,892	$214,161	$0	$0	$0
058b	MO301678	Northwest Region	$939,289	$593,280	$318,633	$0	$0
058d	MO100710	Northwest Region	$1,483	$220	$0	$0	$0
061a	MO101011	Central Region	$381,826	$298,592	$0	$0	$0
061c	MO106101	Central Region	$30,269	$23,513	$0	$0	$0
061d	MO750098	Central Region	$855,305	$648,897	$261,132	$0	$0
061e	MO106671	Central Region	$56,274	$52,894	$0	$0	$0
061i	MO100718	Central Region	$17,952	$7,871	$0	$0	$0
062a	MO902269	Central Region	$647,735	$214,581	$223,885	$56,658	$0
062b	MO100179	Central Region	$425,815	$265,169	$0	$70,016	$0
062c	MO105475	Central Region	$16,987	$11,701	$0	$3,089	$0
062d	MO750056	Central Region	$74,414	$76,753	$0	$20,266	$0
062e	MO100187	Central Region	$199,725	$91,333	$1,273	$24,115	$0
062i	MO105285	Central Region	$18,120	$5,652	$0	$1,492	$0
062j	MO100776	Central Region	$12,246	$6,952	$374	$1,836	$0
062k	MO100483	Central Region	$10,851				
062l	MO102159	Central Region	$44,900	$28,581	$0	$7,547	$0
062n	MO103207	Central Region	$0	$0	$0	$0	$0
062o	MO100783	Central Region	$25,986	$10,557	$0	$2,788	$0
062p	MO100778	Central Region	$0	$0	$0	$0	$0
062q	MO100809	Central Region	$5,204	$3,891	$0	$1,026	$0
062r	MO100927	Central	$2,653	$1,182	$0	$312	$0

062r	MO100927	Region					
062s	MO106614	Central Region	$17,371	$9,782	$0	$2,583	$0
074a	MO103330	Northwest Region	$19,289	$4,116	$0	$0	$0
074b	MO103348	Southwest Region	$10,808	$2,626	$0	$0	$0
074c	MO100930	Southwest Region	$14,634	$0	$0	$0	$0
074d	MO103355	Southwest Region	$3,602	$7,943	$0	$0	$0
082a	MO901592	Eastern Region	$154,476	$92,057	$0	$0	$0
082b	MO103009	Eastern Region	$142,770	$83,144	$0	$0	$0
082d	MO102209	Eastern Region	$475,869	$316,658	$0	$0	$0
082e	MO101485	Eastern Region	$0	$0	$0	$0	$0
087a	MO106598	Northwest Region	$17,843	$35,659	$0	$23,425	$0
087b	MO903127	Northwest Region	$358,326	$426,600	$0	$445,079	$0
089a	MO750403	Eastern Region	$0	$0	$0	$0	$0
089b	MO101033	Eastern Region	$458,557	$389,132	$0	$0	$0
090a	MO101136	Eastern Region	$1,001,211	$635,898	$368,888	$0	$0
090b	MO101458	Eastern Region	$222,128	$181,295	$3,839	$0	$0
090c	MO106069	Eastern Region	$128,845	$66,599	$4,727	$0	$0
090d	MO100381	Eastern Region	$0	$0	$0	$0	$0
090e	MO102803	Eastern Region	$65,437	$36,258	$1,374	$0	$0
090g	MO100765	Eastern Region	$413,591	$407,401	$0	$0	$0
090h	MO100581	Eastern Region	$1,510	$1,769	$14	$0	$0
090i	MO100786	Eastern Region	$38,015	$75,137	$0	$0	$0
153aa	MO101389	Northwest Region	$3,313	$106	$0	$19	$0
153ab	MO101479	Northwest	$6,270	$1,012	$0	$177	$0

153ab	MO101479	Region					
153ac	MO102019	Northwest Region	$426,050	$157,293	$0	$27,530	$0
153ad	MO100624	Northwest Region	$73,965	$7,609		$1,332	
153ae	MO101407	Central Region	$4,397				
153af	MO106093	Central Region	$10,927				
153b	MO105723	Central Region	$113,102	$19,758	$0	$3,458	$0
153c	MO000024	Eastern Region	$844,391	$597,292	$0	$104,538	$0
153d	MO100567	Eastern Region	$28,611	$1,409	$0	$247	$0
153e	MO105715	Eastern Region	$313,525	$57,164	$0	$10,006	$0
153f	MO105046	Central Region	$86,736	$20,040	$0	$3,507	$0
153g	MO105780	Central Region	$20,700	$4,693	$0	$821	$0
153h	MO103942	Central Region	$54,691	$11,219	$0	$1,964	$0
153i	MO101797	Central Region	$40,906	$195,210	$0	$28,462	$0
153j	MO105038	Northwest Region	$81,280	$17,728	$0	$3,103	$0
153k	MO105210	Northwest Region	$42,545	$26,768	$0	$4,686	$0
153l	MO101169	Central Region	$631,221	$198,858	$0	$34,806	$0
153m	MO103892	Northwest Region	$28,510	$22,225	$0	$3,890	$0
153n	MO103900	Northwest Region	$438,393	$252,039	$0	$44,114	$0
153o	MO000025	Northwest Region	$262,032	$81,651	$0	$14,292	$0
153q	MO100668	Central Region	$589,835	$393,905	$0	$68,945	$0
153t	MO100768	Eastern Region	$280,754	$106,236	$0	$18,595	$0
153v	MO100714	Northwest Region	$0	$0	$0	$0	$0
153w	MO100503	Eastern Region	$8,833	$1,302	$0	$228	$0
153x	MO100608	Eastern	$0	$0	$0	$0	$0

153x	MO100606	Region					
153y	MO100871	Northwest Region	$2,267	$404	$0	$71	$0
153z	MO101388	Northwest Region	$3,895	$1,614	$0	$282	$0
154a	MO100526	Northwest Region	$331,581	$206,559	$0	$0	$0
154aa	MO101438	Southwest Region	$115,316				
154b	MO301785	Northwest Region	$316,229	$208,872	$0	$0	$0
154c	MO101441	Northwest Region	$718,819	$405,990	$0	$0	$0
154k	MO100870	Northwest Region	$179,851	$514			
154o	MO101067	Northwest Region	$50	$0	$0	$0	$0
154p	MO101477	Southwest Region	$7,316				
154q	MO101480	Southwest Region	$11,684				
154r	MO101483	Southwest Region	$18,239				
154s	MO101489	Southwest Region	$6,290				
154t	MO101439	Southwest Region	$162				
154u	MO101368	Northwest Region	$22,739	$4,089			
154v	MO101478	Northwest Region	$159,248				
154w	MO101481	Southwest Region	$13,615				
154x	MO101442	Southwest Region	$10,514				
154y	MO101437	Northwest Region	$8,646				
154z	MO101484	Southwest Region	$11,707				
156b	MO101029	Southwest Region	$363,116	$284,346	$284,345	$0	$0
156c	MO100287	Southwest Region	$28,489	$15,915	$15,915	$0	$0
156d	MO101032	Southwest Region	$0	$0	$0	$0	$0
158a	MO000022	Southeast	$410,147	$194,365	$0	$16,028	$0

158a	MO000022	Region					
158b	MO103157	Southeast Region	$91,181	$30,903	$0	$2,548	$0
158c	MO902319	Southeast Region	$478,214	$233,291	$0	$19,238	$0
158d	MO105095	Southeast Region	$85,345	$22,166	$0	$1,828	$0
158e	MO102571	Southeast Region	$57,934	$38,644	$0	$3,187	$0
158f	MO106705	Southeast Region	$67,426	$56,091	$0	$4,625	$0
158g	MO903853	Southeast Region	$346,511	$99,661	$0	$8,218	$0
158h	MO000021	Southeast Region	$116,577	$32,820	$0	$2,706	$0
158j	MO103165	Southeast Region	$41,215	$12,171	$0	$1,004	$0
158k	MO103140	Southeast Region	$95,600	$28,168	$0	$2,323	$0
158l	MO100928	Southeast Region	$33,044	$19,216	$0	$1,585	$0
158m	MO903259	Southeast Region	$17,146	$99,897	$0	$8,238	$0
158n	MO100730	Southeast Region	$131,018	$28,196	$0	$2,325	$0
158o	MO101468	Southeast Region	$5,911				
158p	MO101451	Southeast Region	$14,808				
158q	MO101469	Southeast Region	$11,836				
158r	MO101471	Southeast Region	$3,268				
158s	MO101470	Southeast Region	$3,998				
188a	MO100922	Southwest Region	$104,298	$161,543	$0	$0	$0
201a	MO103587	Northwest Region	$900,820	$0	$0	$0	$0
207a	X	Southwest Region	$0	$0	$0	$0	$0
208a	MO103850	Eastern Region	$135,667	$15,642	$0	$0	$0
210a	MO101623	Eastern Region	$45,179	$6,209	$0	$0	$0
210b	MO103462	Eastern	$78,499	$7,256	$0	$0	$0

210b	MO105462	Region					
210c	MO106077	Eastern Region	$18,666	$3,209	$0	$0	$0
210d	MO103884	Eastern Region	$63,882	$6,865	$0	$0	$0
210e	MO100713	Eastern Region	$5,287	$1,505	$0	$0	$0
210f	MO100712	Eastern Region	$85,220	$10,198	$0	$0	$0
238a	X	Southeast Region	$21,040				
249a	MO105434	Southeast Region	$4,720	$0	$0	$0	$0
249b	MO105442	Southeast Region	$0	$0	$0	$0	$0
249c	MO105426	Eastern Region	$135,414	$23,537	$0	$0	$0
249e	MO105459	Eastern Region	$19,947	$1,451	$0	$0	$0
249f	MO100738	Southeast Region	$317	$0	$0	$0	$0
249g	MO100739	Southeast Region	$2,684	$0	$0	$0	$0
249h	MO100734	Eastern Region	$0	$19	$0	$0	$0
249i	MO100737	Eastern Region	$0	$0	$0	$0	$0
249j	MO101228	Eastern Region	$28,311	$4,748	$0	$0	$0
249k	MO101347	Eastern Region	$20,039	$3,960	$0	$0	$0
249l	MO105418	Eastern Region	$40,003	$4,123	$0	$0	$0
249m	MO102035	Eastern Region	$87,090	$9,148			
249n	MO101269	Eastern Region	$3,466				
250a	MO100729	Northwest Region	$46,754	$9,852	$0	$0	$0
250b	MO102068	Northwest Region	$330,261	$15,056	$0	$0	$0
250c	MO103470	Northwest Region	$63,890	$10,438	$0	$0	$0
250d	MO105251	Northwest Region	$62,759	$9,546	$0	$0	$0
250e	MO105988	Northwest	$67,616	$6,316	$0	$0	$0

256e	MO105988	Region					
275a	MO103868	Central Region	$55,680	$0	$0	$0	$0
275b	MO100711	Central Region	$64,919	$12,678			
277a	MO100719	Southeast Region	$872				
312a	MO903879	Southwest Region	$332,945	$305,777	$338,413	$0	$0
315a	MO100688	Eastern Region	$0	$276	$0	$0	$0
315b	MO100767	Eastern Region	$128,966	$18,463			
Totals:			**$37,138,206**	**$18,652,650**	**$2,683,718**	**$6,113,644**	**$0**

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
002	NORTHWEST MO PSYCHIATRIC REHAB CENTER	3505 Frederick St. Joseph, MO 64506 816-387-2329
008	CENTRAL OFFICE	1706 E. Elm Street Jefferson City, MO 65101 573-751-4942
052	Ozark Center	3006 McClelland Blvd. Joplin, MO 64803 417-347-7600
152	NATIONAL COUNCIL ON ALCOHOLISM & DRUG ABUSE - ST LOUIS AREA INC	8790 Manchester Road St. Louis, MO 63144 314-962-3456
154	KANSAS CITY COMMUNITY CENTER	1730 Prospect Avenue Kansas City, MO 64127 816-421-6670
171	NATIONAL COUNCIL OF GREATER KANSAS CITY	633 E. 63rd Street Kansas City, MO 64110 816-361-5900
208	LIBERTY PROGRAM INC.	929 Fee Fee Road Suite 203 Maryland Heights, MO 63043 314-434-9441
209	SAFETY COUNCIL OF THE OZARKS	1111 South Glenstone Springfield, MO 65804 417-869-2121
210	EASTERN MISSOURI ALTERNATIVE	2724 Draste Road St. Charles, MO 63301 636-946-2815
211	MARTY ENTERPRISES (DBA AFFILIATED COURT SERVICES)	800 North Providence Ste. 104 Columbia, MO 65203 573-499-3784
216	CAAREC	326 Cherry Street Chillicothe, MO 64601 660-646-1652
217	CENTRAL STATES MENTAL HEALTH CON	3217 S. Owens School Road Independence, MO 64057 816-224-4417
220	RASSE DAVID R & ASSOC	78 West Arrow Marshall, MO 65340

	ASSOC	660-886-3373
227	SAFETY COUNCIL OF GREATER ST LOUIS	1015 Locust Street Suite 902 St. Louis, MO 63101 314-621-9200
231	TRAFFIC SAFETY AWARENESS	PO Box 575 Linn Creek, MO 65052 573-346-3829
249	COMMUNITY SERVICES OF MO INC.	1175 Cave Springs Estate Drive St. Peters, MO 63376 636-441-9002
252	ACCREDITED TRAFFIC OFFENDER SERV	1515 E. Malone Sikeston, MO 63801 573-471-7710
264	DOOR TO HOPE COUNSELING AND EDUCATION LLC	PO Box 1049 Nixa, MO 65714 417-724-9767
267	MISSOURI ASSOCIATION OF COMMUNITY TASK FORCES	428 E. Capitol Avenue Second Floor Jefferson City, MO 65101 573-635-6669
274	ALCOHOL DRUG CONSULTANTS	1736 East Sunshine Suite 214 Springfield, MO 65804 417-848-4565
277	HEARTLAND ALTERNATIVE SERVICE PROG	405 Poplar Street Poplar Bluff, MO 63901 573-686-5488
282	ST JOSEPH SAFETY & HEALTH COUNCIL	118 South Fifth Street (Lower Level) St. Joseph, MO 64501 816-233-3330
287	DEAF HOPE	PO Box 14441 Shawnee Mission, KS 66215 913-281-4875
288	SOUTH CENTRAL MO CITIZEN'S ADVISORY	1580 Imperial Center West Plains, MO 65775 417-257-7568
297	ABOUT FACE MENTAL HEALTH SERVICES LLC	6301 Rockhill Road Suite 105 Kansas City, MO 64131 816-444-6200
315	Assessment & Counseling Solutions-Kirkwood	1200 South Kirkwood Rd. Kirkwood, MO 63122 314-849-2800
316	JONES TIMOTHY MA INC	309 West 4th Street Suite 101 Washington, MO 63090 636-239-2054
401	COMMUNITY HOUSING	2600 East 12th Street Kansas City, MO 64127

	NETWORK INC	816-482-5744
402	COVINGTON AND BURLING	1201 Pennsylvania Ave NW PO Box 7566 Washington, DC 20044 202-662-5410
403	OXFORD HOUSE INC.	1010 Wayne Avenue Suite 300 Silver Spring, MD 20910 301-587-2916
405	UNIVERSITY OF MO - COLUMBIA	Sponsored Programs Admin 310 Jesse Hall Columbia, MO 65211 573-882-9587
406	BIG BROTHERS BIG SISTERS	501 North Grand Blvd St. Louis, MO 63103 314-361-5900
408	COMMUNITY PARTNERSHIP OF OZARKS	330 N. Jefferson Springfield, MO 65806 417-888-2020
411	DISCOVERING OPTIONS	909 Purdue Avenue St. Louis, MO 63130 314-721-8116
412	FRIENDS WITH A BETTER PLAN	5622 Delmar Suite 102E St. Louis, MO 63112 314-361-2371
413	LEAD INSTITUTE THE	2502 West Ash Columbia, MO 65203 573-817-2400
414	LINCOLN UNIVERSITY	Business & Finance 306 Young Hall PO Box 29 Jefferson City, MO 65102 573-681-5058
416	MO ALLIANCE OF BOYS/GIRLS CLUB	1460 Bee Creek Road Branson, MO 65616 417-335-2089
417	PREVENTION CONSULTANTS OF MO	104 East 7th Street Rolla, MO 65401 573-368-4755
418	SOUTHEAST MO STATE UNIVERSITY	One University Plaza MS 3000 Cape Girardeau, MO 63701 573-651-2018
420	UNITED WAY OF THE OZARKS	320 N. Jefferson Springfield, MO 65806 417-863-7700
421	UNIVERSITY OF OKLAHOMA	Office of Proj & Compl Ass. 660 Parrington Oval 324 Norman, OK 73019 918-660-3700

423	SAVE INC.	PO Box 45301 Kansas City, MO 64171 816-531-8340
428	Marty Enterprises	800 North Providence Columbia, MO 65203 573-499-3784
430	OZARKS AREA COMMUNITY ACTION	215 South Barnes Avenue Springfield, MO 65802 417-864-3492
431	OFFICE OF STATE COURTS ADMINISTRATION	2112 Industrial Drive PO Box 104480 Jefferson City, MO 65110 573-751-4377
432	Nextalk Inc	2825 East Cottonwood Parkway Suite 120 Salt Lake City , UT 84121 801-274-6001
433	Amethyst Place Kansas City	1102 Benton , 1 N Kansas City, MO 64127 816-231-8782
207a	CORRECTION SERVICES	2200 E. Sunshine Suite 320 Springfield, MO 65804 417-869-5161
238a	Meramec Recovery Center - Washington	500 East Hwy. 100 Washington, MO 63090 800-886-5860

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1

	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Drop-Outs [3]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Education programs for youth groups [14]	13
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training,	18

	impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco,	13

	and other drug use [52]	
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	4
	Ongoing classroom and/or small group sessions [12]	8
	Mentors [15]	5
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	8
	Prevention Assessment and Referral [34]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	13
Physically Disabled [7]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training,	18

	impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Abuse Victims [8]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13
Already Using Substances [9]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	18
	Systematic planning [42]	13
	Multi-agency coordination and collaboration/coalition [43]	13
	Community team-building [44]	13
	Accessing services and funding [45]	13

Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	13
	Resources directories [2]	14
	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Multi-agency coordination and collaboration/coalition [43]	13

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

	Number of Admissions ≥ Number of Persons		Costs per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24-Hour Care)					
Hospital Inpatient	204	189	$ 5296	$ 1845	$ 10318
Free-standing Residential	7645	5496	$ 429	$ 275	$ 553
Rehabilitation / Residential					
Hospital Inpatient	0		$	$	$
Short-term (up to 30 days)	17274	13868	$ 1706	$ 1644	$ 1531
Long-term (over 30 days)	0		$	$	$
Ambulatory (Outpatient)					
Outpatient	18557	15843	$ 522	$ 431	$ 512
Intensive Outpatient	20778	16207	$ 740	$ 448	$ 986
Detoxification	0		$	$	$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	671	382	$ 1136	$ 842	$ 1098

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	1,943	939	473	353	65	0	0	1	1	3	1	39	15	42	11	1,330	548	47	18
2. 18-24	6,590	3,654	1,489	927	224	4	0	9	3	13	3	130	49	62	23	4,693	1,747	106	44
3. 25-44	17,710	9,104	4,120	2,803	1,015	9	3	20	5	28	14	246	129	166	48	12,117	5,238	259	96
4. 45-64	6,730	3,548	1,125	1,465	385	0	1	5	1	16	8	91	20	57	8	5,095	1,534	87	14
5. 65 and over	116	66	17	28	1	0	0	1	0	0	0	1	0	2	0	96	18	2	0
6. Total	33,089	17,311	7,224	5,576	1,690	13	4	36	10	60	26	507	213	329	90	23,331	9,085	501	172
7. Pregnant Women	470		341		110		0		0		0		16		3		461		9

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? Yes No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period. 10,628

Numbers of Persons Served outside of the levels of care described in Form 10a. 11,147

Persons served outside of the Form 10b levels of care include those individuals who were served outside of the Form 10b levels of care with received recovery supports, Department of Corrections education, Weekend Intervention Program, or early intervention services.

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations

TB SERVICES

The Department of Mental Health (DMH) - Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections (DOC), Missouri Department of Health and Senior Services (DHSS), and the Missouri Department of Social Services (DSS), MO HealthNet Division (Medicaid) to collect the information required to report the statewide non-federal cost of Tuberculosis (TB) services provided to citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for TB services to substance abusers in treatment have been calculated with the following methodology:

The Department of DOC provides aggregated costs of TB services to inmates in correctional facilities, and associated costs to those inmates in institutional substance abuse treatment programs.

The Department of DHSS provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The Department of DSS provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH Customer Information Management, Outcomes, & Reporting (CIMOR) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the CIMOR system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds).

Table 1 Methodology for Determining the Cost of Tuberculosis Services Provided to Substance Abusers in Treatment.

A	B	C	D
Agency	**Total of All State funds spent on TB services**	**% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment**	**Total State Funds Spent on Clients who were Substance Abusers in Treatment**
ADA non-Medicaid	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system	Column D / Column B	State non-Medicaid expenditures for TB treatment provided by ADA funded programs per the DMH (CIMOR) data system
Medicaid	State Medicaid expenditures for claims with TB diagnosis codes per the	Column D / Column B	State Medicaid expenditures for TB treatment provided by ADA

A	B	C	D
Agency	**Total of All State funds spent on TB services**	**% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment**	**Total State Funds Spent on Clients who were Substance Abusers in Treatment**
	Missouri Medicaid Management System (MMIS)		funded programs per the DMH (CIMOR) data system
Department of Corrections (DOC)	State expenditures for TB services provided in correctional facilities. Computed as the total number of inmates multiplied by the average TB treatment cost per day multiplied by average length of incarceration per inmate	Column D / Column B	The number of inmates receiving substance abuse treatment in correctional facilities multiplied by the average TB treatment cost per day multiplied by the average length of incarceration per inmate
Department of Health and Senior Services (DHSS)	Total State expenditures for TB services per DHSS	Column D / Column B	The number of clients referred from ADA funded treatment programs to local health departments for TB testing multiplied by average State expenditures for TB testing -plus- The number of clients treated for TB by local health departments multiplied by average State expenditures for TB treatment
Total	Sum of Rows Above	Sum of Rows Above	Sum of Rows Above

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The Division of ADA used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children:

For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The required base expenditures were calculated as $7,728,020.

The DMH CIMOR fee-for-service payment system uses detailed coding to capture services delivered to pregnant women and women with dependent children by procedure code. The total expenditures on these qualified programs were $9,661,268 for SFY 2010 which exceeds the required base expenditure.

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2007) + B2(2008) / 2 (C)
SFY 2008 (1)	**$44,753,120**	**$46,777,162**
SFY 2009 (2)	**$48,801,203**	
SFY 2010 (3)	$ 49,809,906	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2008 (•) Yes ( ) No
FY 2009 (•) Yes ( ) No
FY 2010 (•) Yes ( ) No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2010 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

(•) Yes ( ) No If yes, specify the amount and the State fiscal year: $ 286477 , 2008(SFY)

Did the State include these funds in previous year MOE calculations?

( ) Yes (•) No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date) 8/29/2008

TB (MOE TABLE II)

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 -------- 2 (D)
SFY 1991 (1)	$ 421,670	0.06 %	$ 253	$ 1,265
SFY 1992 (2)	$ 455,117	0.50 %	$ 2,276	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2010 (3)	$ 407,513	9.535107811219 %	$ 38,857

HIV (MOE TABLE III)

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 --- 2 (B)
SFY 1993 (1)	$ 298,242	$ 301,434
SFY 1994 (2)	$ 304,625	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2010 (3)	$

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	**$7,728,020**	
2008		**$9,366,605**
2009		**$10,238,872**
2010		$ 9,661,268

Enter the amount the State plans to expend in FY 2011 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $ 9,661,268

Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2009

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**3,250**	**3,208**
Total number of clients with non-missing values on employment\student status [denominator]	**15,323**	**15,323**
Percent of clients employed (full-time and part-time) or student	**21.2%**	**20.9%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**13,604**
Number of CY 2009 discharges submitted:	**17,012**
Number of CY 2009 discharges linked to an admission:	**16,884**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,704**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**15,323**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]		
Total number of clients with non-missing values on employment\student status [denominator]		
Percent of clients employed (full-time and part-time) or student		

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**0**
Number of CY 2009 discharges submitted:	**0**
Number of CY 2009 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**5,164**	**5,697**
Total number of clients with non-missing values on employment\student status [denominator]	**16,076**	**16,076**
Percent of clients employed (full-time and part-time) or student	**32.1%**	**35.4%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**16,487**
Number of CY 2009 discharges submitted:	**20,462**
Number of CY 2009 discharges linked to an admission:	**20,091**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**19,394**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**16,076**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients employed (full-time and part-time) or student [numerator]	**6,824**	**7,370**
Total number of clients with non-missing values on employment\student status [denominator]	**14,303**	**14,303**
Percent of clients employed (full-time and part-time) or student	**47.7%**	**51.5%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**14,089**
Number of CY 2009 discharges submitted:	**17,799**
Number of CY 2009 discharges linked to an admission:	**17,517**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,745**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**14,303**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2009

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**12,399**	**12,707**
Total number of clients with non-missing values on living arrangements [denominator]	**13,615**	**13,615**
Percent of clients with stable housing	**91.1%**	**93.3%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**13,604**
Number of CY 2009 discharges submitted:	**17,012**
Number of CY 2009 discharges linked to an admission:	**16,884**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,704**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**13,615**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]		
Total number of clients with non-missing values on living arrangements [denominator]		
Percent of clients with stable housing		

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**0**
Number of CY 2009 discharges submitted:	**0**
Number of CY 2009 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**0**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**0**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**13,463**	**13,507**
Total number of clients with non-missing values on living arrangements [denominator]	**13,989**	**13,989**
Percent of clients with stable housing	**96.2%**	**96.6%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**16,487**
Number of CY 2009 discharges submitted:	**20,462**
Number of CY 2009 discharges linked to an admission:	**20,091**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**19,394**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**13,989**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with stable housing [numerator]	**12,836**	**12,892**
Total number of clients with non-missing values on living arrangements [denominator]	**12,997**	**12,997**
Percent of clients with stable housing	**98.8%**	**99.2%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**14,089**
Number of CY 2009 discharges submitted:	**17,799**
Number of CY 2009 discharges linked to an admission:	**17,517**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	**16,745**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**12,997**
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2009

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**12,274**	**13,782**
Total number of clients with non-missing values on arrests [denominator]	**14,590**	**14,590**
Percent of clients with no arrests	**84.1%**	**94.5%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**13,604**
Number of CY 2009 discharges submitted:	**17,012**
Number of CY 2009 discharges linked to an admission:	**16,884**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**16,788**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**14,590**
Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]		
Total number of clients with non-missing values on arrests [denominator]		
Percent of clients with no arrests		

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**0**
Number of CY 2009 discharges submitted:	**0**
Number of CY 2009 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**0**
Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**14,240**	**14,422**
Total number of clients with non-missing values on arrests [denominator]	**15,407**	**15,407**
Percent of clients with no arrests	**92.4%**	**93.6%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**16,487**
Number of CY 2009 discharges submitted:	**20,462**
Number of CY 2009 discharges linked to an admission:	**20,091**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**20,005**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**15,407**
Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients with no arrests [numerator]	**13,584**	**13,475**
Total number of clients with non-missing values on arrests [denominator]	**14,200**	**14,200**
Percent of clients with no arrests	**95.7%**	**94.9%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**14,089**
Number of CY 2009 discharges submitted:	**17,799**
Number of CY 2009 discharges linked to an admission:	**17,517**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**17,216**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**14,200**
Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2009

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]	**8,184**	**13,056**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**15,271**	**15,271**
Percent of clients abstinent from alcohol	**53.6%**	**85.5%**
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		**4,986**
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**7,087**	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		**70.4%**
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		**8,070**
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**8,184**	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		**98.6%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**13,604**
Number of CY 2009 discharges submitted:	**17,012**
Number of CY 2009 discharges linked to an admission:	**16,884**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**16,788**
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**15,271**

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
[Records received through 5/6/0010]

Long-term Residential(LR)		
A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from alcohol		
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	0
Number of CY 2009 discharges submitted:	0
Number of CY 2009 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	0
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file

[Records received through 5/6/0010]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol [numerator]	13,189	15,487
All clients with non-missing values on at least one substance/frequency of use [denominator]	16,716	16,716
Percent of clients abstinent from alcohol	78.9%	92.6%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,813
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,527	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		79.8%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		12,674
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	13,189	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	16,487
Number of CY 2009 discharges submitted:	20,462
Number of CY 2009 discharges linked to an admission:	20,091
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	20,005
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	16,716

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file

[Records received through 5/6/0010]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol [numerator]	12,190	14,639
All clients with non-missing values on at least one substance/frequency of use [denominator]	15,375	15,375
Percent of clients abstinent from alcohol	79.3%	95.2%

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		2,840
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,185	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		89.2%

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		11,799
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	12,190	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.8%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	14,089
Number of CY 2009 discharges submitted:	17,799
Number of CY 2009 discharges linked to an admission:	17,517
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	17,216
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	15,375

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
[Records received through 5/6/0010]

Form T5

Form T5 was pre-populated with the following Data Source: Discharges in CY 2009

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs [numerator]	**4,924**	**12,031**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**15,271**	**15,271**
Percent of clients abstinent from drugs	**32.2%**	**78.8%**
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**7,220**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**10,347**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**69.8%**
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	**At Admission (T_1)**	**At Discharge(T_2)**
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**4,811**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**4,924**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**97.7%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**13,604**
Number of CY 2009 discharges submitted:	**17,012**
Number of CY 2009 discharges linked to an admission:	**16,884**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**16,788**

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**15,271**

Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]		
All clients with non-missing values on at least one substance/frequency of use [denominator]		
Percent of clients abstinent from drugs		

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]		
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**0**
Number of CY 2009 discharges submitted:	**0**
Number of CY 2009 discharges linked to an admission:	**0**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**0**

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**0**

Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]	**11,466**	**14,607**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**16,716**	**16,716**
Percent of clients abstinent from drugs	**68.6%**	**87.4%**

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**3,957**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**5,250**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**75.4%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**10,650**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**11,466**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**92.9%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**16,487**
Number of CY 2009 discharges submitted:	**20,462**
Number of CY 2009 discharges linked to an admission:	**20,091**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**20,005**

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**16,716**

Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs [numerator]	**13,419**	**14,418**
All clients with non-missing values on at least one substance/frequency of use [denominator]	**15,375**	**15,375**
Percent of clients abstinent from drugs	**87.3%**	**93.8%**

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		**1,590**
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**1,956**	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T2 / #T1 x 100]		**81.3%**

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T_1)	At Discharge(T_2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		**12,828**
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	**13,419**	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]		**95.6%**

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	**14,089**
Number of CY 2009 discharges submitted:	**17,799**
Number of CY 2009 discharges linked to an admission:	**17,517**
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	**17,216**

Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	**15,375**

Source:SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]

Form T6

Most recent year for which data are available	From: 7/1/2008 To: 6/30/2009

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T_1)	Discharge Clients (T_2)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	6486	10137
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	41957	41957
Percent of clients participating in social support activities	15.46%	24.16%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described

Since October 2006, a self-help indicator is collected in the State's information system at admission, at changes in level of care, and at discharge. The self-help indicator was formulated based on the GPRA self-help question. In May 2010, the State began collecting the new TEDS self-help indicator.

DATA SOURCE

What is the source of data for table T6? (Select all that apply)

- [x] Client Self Report
  - Client self-report confirmed by another source:
    - [ ] Collateral source
    - [ ] Administrative data source
- [ ] Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T6? (Select one)

- (•) Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- ( ) Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T6? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge
  - Specify:
    - ( ) In-Treatment data ____ days post admission
    - ( ) Follow-up data ____ months post admission
    - ( ) Other, Specify:
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- [ ] Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ◉ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing self-help participation status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Form T7

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From: 1/1/2009 To: 12/31/2009

Length of Stay			
Level of Care	**Average**	**Median**	**Interquartile Range**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential	2.69	3	1.00
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)	27.64	22	11.00
5. Long-term (over 30 days)			
Ambulatory (Outpatient)			
6. Outpatient	87.45	72	90.50
7. Intensive Outpatient	79.20	71.50	71.00
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. Opioid Replacement therapy	788.25	414.50	1200.50

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

Treatment Performance Measures

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA), as the Single State Authority (SSA) has used data-driven decisions based on a limited number of performance measures in the past. Effective October 1, 2006 the SSA implemented a web-based information system Customer Information Management, Outcomes, and Reporting System (CIMOR). CIMOR replaced multiple legacy systems – integrating billing and client tracking. This system has been designed to capture the data elements needed for Treatment Episode Dataset / National Outcomes Measures (TEDS/NOMS) reporting at admission, at level changes, and at discharge.

Design flaws in the CIMOR data model, however, have impacted the data integrity of the State's outcome data. Initially, updates to the TEDS data resulted in overwriting of previously collected data. A fix was implemented in July 2007 but caused other difficulties in linking records in related tables. Work to re-design the tables began in spring 2008. The new TEDS screens and data tables went into production in May 2010.

ADA continues to use data quality reporting to notify service providers of missing or inconsistent data. In FY 2009, ADA developed a process to identify duplicate ids assigned to the same consumer. When identified, these ids are forwarded to the help desk staff for consolidation. During spring 2009, ADA began requiring verified social security numbers which has helped reduce the number of duplicate ids assigned to the same consumer. ADA continues to maintain and distribute the ADA Data Guidance Document which provides definitions and instructions for much of its data including the TEDS/NOMS data:

http://dmh.mo.gov/ada/ADACIMORGuidanceDocumentNewTEDS5-18-2010.pdf

ADA is in the process of deploying an on-demand, provider-level NOMS report to CIMOR. This report will allow providers to view their agencies NOMS data and comparable statewide data by program. With the new TEDS screens, ADA is also collecting data on babies born drug-free for female consumers and grade point average data for adolescent programs. This data is used by ADA as outcomes measures for budget justification. Starting in FY 2011, quarterly summary reports of outcome data will be sent to ADA provider directors.

With its Access to Recovery II (ATR II) program, ADA has implemented performance monitoring reports with regard to the GPRA follow-up collection. ATR II service providers are able to compare their follow-up rates with that of any other ATR II provider. Additional reports have been implemented for GPRA NOMS data – allowing providers to compare their data with statewide ATR II benchmarks. In FY 2010, ATR II providers received incentive payments if their GPRA follow-up rate was above a set benchmark and the amount of payment was based on the number of GPRA follow-ups collected.

ADA requires providers to supply information about the intensity and number of services provided to consumers via the CIMOR system. Service data are being used to

determine retention, transition to other levels of care, individualization of services, and utilization of medication assisted treatment and motivational interviewing. During FY 2011, ADA will continue to develop and implement process measure reports based on service data. These reports will address various issues including, but not limited to, data collection and reporting efforts; treatment planning, engagement, and retention; and business practices. The reports will be used in monitoring efforts and to target technical assistance.

In 2006, ADA, in conjunction with the Center for Substance Abuse Treatment (CSAT), provided training on the importance of the national outcome measures under the professional development track at the Spring Training Institute. With the implementation of CIMOR in fall 2006, ADA conducted face-to-face provider trainings across the state during 2006 and 2007. In fall 2009, ADA began quarterly webinars for providers covering various CIMOR functionalities, billing procedures, and emerging issues. In March 2010, ADA research staff conducted a training webinar for ADA service providers on the redesigned TEDS screens and data quality issues. On an as needed basis, CIMOR alerts are sent to executive directors and CIMOR liaisons at provider agencies. These alerts provide information on policies and procedures that impact CIMOR data collection and reporting. Updates to the ADA Guidance Document are communicated to providers via CIMOR alerts as well as posting the updated version to the ADA website.

ADA continues to seek outside data linkages to be used to assess data quality in ADA's information infrastructure as well as to expand its information base. During 2009, ADA established linkage with the Department of Revenue driver's license records containing DWI administrative data. This data was used to assess the data quality and referral process for ADA's traffic offender program. Also, ADA has established linkage with the Department of Corrections (DOC) to monitor prison recidivism for those parolees and probationers who are receiving substance abuse treatment. During FY 2011, ADA plans to seek data linkage with the Department of Health and Senior Services to obtain hospital/emergency room admission data.

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - CY 2008	13.90	
		Ages 18+ - CY 2008	55.10	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.	Ages 12–17 - CY 2008	10.60	
		Ages 18+ - CY 2008	29.60	
3. 30-day Use of Other Tobacco Products	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).	Ages 12–17 - CY 2008	5.60	
		Ages 18+ - CY 2008	9.70	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - CY 2008	6	
		Ages 18+ - CY 2008	5.10	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - CY 2008	4.40	
		Ages 18+ - CY 2008	3.90	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2008	77.40	
		Ages 12–17 - CY 2008	76.10	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - CY 2008	93.40	
		Ages 18+ - CY 2008	95	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 18+ - CY 2008	76.40	
		Ages 12–17 - CY 2008	82.90	

((s)) Suppressed due to insufficient or non-comparable data

Form P3
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - CY 2008	13.20	
		Ages 18+ - CY 2008	16.90	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 18+ - CY 2008	15.40	
		Ages 12–17 - CY 2008	12.90	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2008	19.30	
		Ages 12–17 - CY 2008	13.40	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - CY 2008	13.80	
		Ages 18+ - CY 2008	18	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 18+ - CY 2008	19.80	
		Ages 12–17 - CY 2008	13	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4
NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2008	90.30	
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - CY 2008	88.20	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2008	84.70	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2008	85.20	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - CY 2008	85.30	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 18+ - CY 2008	39	
		Ages 15–17 - CY 2008	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	CY 2008	95.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	CY 2008	37.90	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2008	189	

((s)) Suppressed due to insufficient or non-comparable data

Form P10
NOMs Domain: Social Connectedness
Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - CY 2008	56.40	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - CY 2008	93.80	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11
NOMs Domain: Retention
Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - CY 2008	88.10	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2007	9/30/2008
Form P12b Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity	10/1/2007	9/30/2008
Form P13 (Optional) Number of Persons Served by Type of Intervention	10/1/2007	9/30/2008
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	10/1/2007	9/30/2008
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	10/1/2007	9/30/2008

Form P12a
Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Missouri used the MDS and manual process data collection systems.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Missouri collects and records a participant's race through the MDS system and manual collection process. Participants who were more than one race were reported either under a single race or "race not known or other" - the state does not use more than one race category.

Category	Description	Total Served
A. Age	1. 0-4	1351
	2. 5-11	22574
	3. 12-14	25802
	4. 15-17	13174
	5. 18-20	3174
	6. 21-24	3306
	7.25-44	28169
	8. 45-64	18050
	9. 65 And Over	1280
	10. Age Not Known	166579
B. Gender	Male	50660
	Female	66220
	Gender Unknown	166579
C. Race	White	94396
	Black or African American	20150
	Native Hawaiian/Other Pacific Islander	797
	Asian	1021
	American indian/Alaska Native	765
	More Than One Race (not OMB required)	0
	Race Not Known or Other (not OMB required)	166330
D. Ethnicity	Hispanic or Latino	6961
	Not Hispanic or Latino	109954
	Ethnicity Unknown	166544

Form 12b
Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	19335129
	10. Age Not Known	19335
B. Gender	Male	
	Female	19335129
	Gender Unknown	19335129
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	More Than One Race (not OMB required)	
	Race Not Known or Other (not OMB required)	19335 19335129
D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	
	Ethnicity Unknown	19335 19335129

Form P12B is based on media programs and is a duplicated count.

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Form P14
Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
    - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
    - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
    - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). “Informed experts” may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
Missouri utilizes the Strategic Prevention Framework model to implement the four guidelines. The process includes: assessment of the community needs and readiness; capacity building to mobilize and address the needs of the community; development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs; implementation of the prevention plan; and, evaluation of the results to achieve sustainability and cultural competency. Missouri identifies appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Southwest Regional Expert Team, and SAMHSA’s Center for Substance Abuse Prevention. The Division of Alcohol and Drug Abuse ultimately determines whether or not a chosen intervention falls under the third guideline.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Missouri collects data on the number of programs and strategies through a combined electronic and manual collection process utilizing monthly progress and fidelity reporting forms.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	320	336	656	104	0	760
2. Total number of Programs and Strategies Funded	320	336	656	104	0	760
3. Percent of Evidence-Based Programs and Strategies	100.00%	100.00%	100.00%	100.00%	NaN	100.00%

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant $Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	320	$ 1282545
2. Universal Indirect	336	$ 2621419
3. Selective	104	$ 2209680
4. Indicated	0	$ 0
5. Totals	760	$6,113,644.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note: The Sub-totals for each IOM category and the Total FFY 2008 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See: The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY 2008 Program/Strategy Name Universal Direct	**FFY 2008 Total Number of Evidence-based Programs and Strategies by Intervention**	**FFY 2008 Total Costs of Evidence based Programs and Strategies for each IOM Category**	**FFY 2008 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies**
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	$	
Total FFY 2008 SAPT Block Grant Dollars $ Spent on Evidence-Based Programs and Strategies			$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Attachment A, Goal 2: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (http://www.healthypeople.gov/) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

(•) Yes ( ) No ( ) Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

( ) Yes (•) No ( ) Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
( ) Yes	( ) Yes	( ) Yes
(•) No	(•) No	(•) No
( ) Unknown	( ) Unknown	( ) Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

( ) Yes (•) No ( ) Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? (•) Yes ( ) No ( ) Unknown

Dissemination of materials? (•) Yes ( ) No ( ) Unknown

Media campaigns? (•) Yes ( ) No ( ) Unknown

Product pricing strategies? (•) Yes ( ) No ( ) Unknown

Policy to limit access? (•) Yes ( ) No ( ) Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

(•) Yes ( ) No ( ) Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to

alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

	Yes	No	Unknown
Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers:	○	◉	○
New product pricing:	○	◉	○
New taxes on alcoholic beverages:	○	◉	○
New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors:	○	◉	○
Parental responsibility laws for a child's possession and use of alcoholic beverages:	○	◉	○

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

◉ Yes ○ No ○ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	○	○	◉	○
Alcohol	○	○	◉	○
Marijuana	○	○	◉	○

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older?	0.08
Motor vehicle drivers under age 21?	0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 164

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

○ Yes ◉ No ○ Unknown

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

This narrative response not included because it does not exist or has not yet been submitted.